Health

Annual Report
2016-17

Alberta

Note to Readers:
Copies of the annual report are available on the Ministry of Health website:
www.health.alberta.ca

Alberta Health
Communications
PO Box 1360, Station Main
Edmonton, AB T5J 1S6

Phone: 780-638-3225
Fax: 780-427-1171

Information about the entities that were part of the Ministry of Health in 2016-17 is available on their respective websites:

Alberta Health Services
www.albertahealthservices.ca

Health Quality Council of Alberta
www.hqca.ca

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Preface

The Public Accounts of Alberta are prepared in accordance with the *Financial Administration Act* and the *Fiscal Planning and Transparency Act*. The Public Accounts consist of the annual report of the Government of Alberta and the annual reports of each of the 21 ministries.

The annual report of the Government of Alberta contains ministers' accountability statements, the consolidated financial statements of the province and *Measuring Up* report, which compares actual performance results to desired results set out in the government's strategic plan.

This annual report of the Ministry of Health contains the minister's accountability statement, the audited consolidated financial statements of the ministry and a comparison of actual performance results to desired results set out in the ministry business plan. This ministry annual report also includes:

- **the financial statements of entities making up the ministry including the Department of Health, Alberta Health Services, and Health Quality Council of Alberta, for which the minister is responsible;**
- **other financial information as required by the *Financial Administration Act* and *Fiscal Planning and Transparency Act*, either as separate reports or as a part of the financial statements, to the extent that the ministry has anything to report.**

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Minister's Accountability Statement

The ministry's annual report for the year ended March 31, 2017, was prepared under my direction in accordance with the *Fiscal Planning and Transparency Act* and the government's accounting policies. All of the government's policy decisions as at June 2, 2017, with material economic or fiscal implications of which I am aware have been considered in the preparation of this report.

[Original Signed by]

Honourable Sarah Hoffman
Minister of Health

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Message from the Minister

I have had the honour of serving Albertans as the province's Minister of Health for the past two years. My goal continues to be for Albertans to receive the right health care, in the right place, at the right time.

Over the past year, we have made progress on several initiatives that will improve health outcomes for Albertans. We are taking an important step to improve the way we deliver health services to Albertans with our shift toward community-based care. This includes work on strengthening our primary health care and mental health systems, and providing continuing care services closer to home.

Another major initiative this year has been our work with the Alberta Medical Association to implement an amending agreement with the province's physicians. This agreement helps meet our promise to slow the growth of health spending while improving and protecting services.

In the fall of 2016, government passed the *Public Health Amendment Act*, which will help us improve our childhood immunization rates and our response to outbreaks in schools. In addition, this spring, government passed the *Voluntary Blood Donations Act*, which protects Alberta's voluntary blood donation system.

We have also continued to make progress on our commitment to add 2,000 new long-term care and dementia spaces in Alberta, and have expanded access to health services throughout the province, including Lethbridge, Edson and High Prairie.

We have accomplished much in the past year, and it would not have been possible without the hard work and dedication of staff at the Ministry of Health. As I look forward to next year, I am excited about continuing to make life better for Albertans by supporting a strong public health care system.

[Original signed by]

Honourable Sarah Hoffman
Minister of Health

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Message from the Associate Minister

It is my privilege to work with Minister Hoffman and the staff in the Ministry of Health to provide quality health care to Albertans. Since becoming Associate Minister of Health in February 2016, I have truly been impressed by the knowledge, skills and commitment of the staff at Alberta Health and Alberta Health Services as they address many complex issues that impact the health and well-being of Albertans.

One of these issues is opioid overdoses. Alberta continues to face a public health crisis with too many people losing their lives. There is much work that needs to be done to address this crisis and government has taken some significant steps over the past year.

We have improved our surveillance and data sharing through public quarterly reporting and began interim reporting in early 2017. We continue to make naloxone available to Albertans through our take-home naloxone program, and in February we expanded access to naloxone by allowing all first responders, including firefighters, to administer naloxone by injection. We are also supporting agencies in their work to bring supervised consumption services to Alberta as quickly as possible. We remain committed to working with our partners on harm-reduction actions.

Work to improve our mental health system to support Albertans also continues. We are working closely with our stakeholders on next steps in addressing the recommendations of the *Valuing Mental Health* review. Government is committed to providing services to vulnerable groups, including children, youth and families, people with complex needs, Indigenous people and communities, and people affected by substance use.

Albertans want and expect a health care system that supports all Albertans. I look forward to continuing our work to provide Albertans with the care and services they need to live healthy lives.

[Original signed by]

Honourable Brandy Payne
Associate Minister of Health

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Management's Responsibility for Reporting

The Ministry of Health includes the Department of Health, Alberta Health Services and the Health Quality Council of Alberta. The executives of the individual entities within the ministry have the primary responsibility and accountability for the respective entities. Collectively, the executives ensure the ministry complies with all relevant legislation, regulations and policies.

Ministry business plans, annual reports, performance results and the supporting management information are integral to the government's fiscal and strategic plan, annual report, quarterly reports and other financial and performance reporting.

Responsibility for the integrity and objectivity of the consolidated financial statements and performance results for the ministry rests with the Minister of Health. Under the direction of the Minister, we oversee the preparation of the ministry's annual report, including consolidated financial statements and performance results. The consolidated financial statements and the performance results, of necessity, include amounts that are based on estimates and judgments. The consolidated financial statements are prepared in accordance with Canadian public sector accounting standards. The performance measures are prepared in accordance with the following criteria:

- Reliability – Information used in applying performance measure methodologies agrees with the underlying source data for the current and prior years' results.
- Understandability – the performance measure methodologies and results are presented clearly.
- Comparability – the methodologies for performance measure preparation are applied consistently for the current and prior years' results.
- Completeness – outcomes, performance measures and related targets match those included in the ministry's Budget 2016.

As Deputy Minister and Associate Deputy Minister, in addition to program responsibilities, we are responsible for the ministry's financial administration and reporting functions. The ministry maintains systems of financial management and internal control which give consideration to costs, benefits, and risks that are designed to:

- provide reasonable assurance that transactions are properly authorized, executed in accordance with prescribed legislation and regulations, and properly recorded so as to maintain accountability of public money;
- provide information to manage and report on performance;
- safeguard the assets and properties of the province under ministry administration;
- provide Executive Council, the President of Treasury Board and Minister of Finance, and the Minister of Health the information needed to fulfill their responsibilities; and
- facilitate preparation of ministry business plans and annual reports required under the *Fiscal Planning and Transparency Act*.

In fulfilling our responsibilities for the ministry, we have relied, as necessary, on the executives of the individual entities within the ministry.

[Original signed by]

Carl G. Amrhein
Deputy Minister of Health
June 2, 2017

[Original signed by]

Andre Tremblay
Associate Deputy Minister of Health
June 2, 2017

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Results Analysis

Ministry Overview

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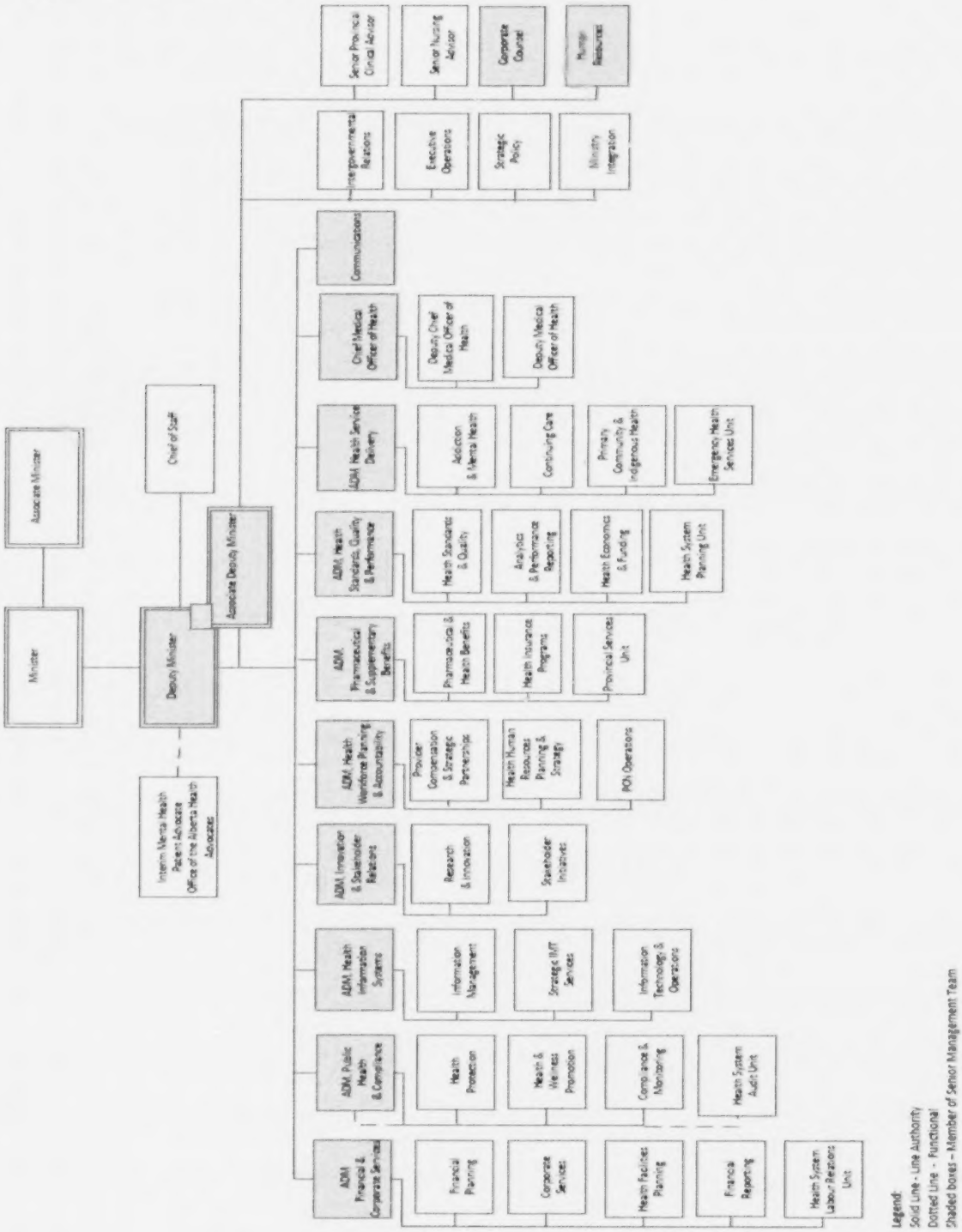
Ministry Overview – The Department of Health



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The Minister of Health is responsible for setting policy and overseeing the health system to ensure the health of Albertans is protected, resources are aligned with the goals of the government, and public dollars are used appropriately. During 2016-17, the ministry was comprised of the Department of Health, Alberta Health Services, and the Health Quality Council of Alberta.

The Department of Health's focus and role is strategic in developing policy, setting standards and regulations, and ensuring accountability on behalf of Albertans. Alberta Health Services is responsible for delivery of a substantial portion of health care services across the province. The Health Quality Council of Alberta is mandated to promote and improve patient safety and health service quality on a province-wide basis.

Receiving direction from the Minister and Associate Minister, the Deputy Minister and Associate Deputy Minister are responsible for the daily operations of the Department of Health, which is structured as follows:

Deputy Minister's Office – provides leadership to the health system to ensure quality health services, drive innovation, and continue to build and maintain collaborative relationships with partners across government ministries, Alberta Health Services, and stakeholder organizations. The Office provides policy co-ordination and issues management for the Minister and Associate Minister as well as leadership in priority-setting, decision-making, and operations of the ministry. In March 2017, an Associate Deputy Minister position was created to assist with the day-to-day management of the ministry to provide more capacity for the Deputy Minister to focus on the delivery of the ministry's priorities and support the transformation of health services.

Financial and Corporate Services Division – forecasts and manages the ministry's budget, funds and monitors the financial activities of the department, provides financial advice and works with the Auditor General in preparing annual financial statements, ensuring compliance with Government of Alberta financial legislation. The division oversees health facilities planning and co-ordinates infrastructure projects with Alberta Infrastructure and Alberta Health Services. The division also provides general administrative and contracting-based corporate services to enable the department to fulfil its mandate, as well as recovery of the cost of health services from wrong-doers.

Public Health and Compliance Division – functions to protect the health of Albertans by providing strategic direction and leadership in the development of provincial policies, regulations, strategies, and standards in compliance monitoring, communicable diseases, immunization, environmental health, emergency preparedness, and health promotion. The division carries out these functions to support innovation and engage Albertans in wellness, health promotion, and injury and disease prevention, and to investigate reports of fraud and non-compliance with standards.

Health Information Systems Division – manages the administration of Alberta's *Health Information Act*, including health information policy and advice, as well as the strategic planning and delivery of information management and technology systems. The division also: provides provincial governance of health information management; develops and implements legislative requirements, policy and best practice information related to the secure exchange of health information; develops information technology solutions to support ministry operations; manages and aligns enterprise-wide information technology asset management solutions; and, manages Alberta Netcare.

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Innovation and Stakeholder Relations Division – facilitates increased innovation adoption in the health care system, with the goal of building the strongest health innovation ecosystem in Canada by accelerating the adoption and diffusion of new innovative health technologies and processes that will improve patient outcomes and add value to the system. The division's responsibilities include: identifying strategic priorities for health research and innovation in co-ordination with Alberta Health Services, Alberta Innovates, post-secondary institutions, and other stakeholders; generating evidence to support innovation and policy development and decision making; facilitating partnerships and other opportunities to bring new innovation into Alberta's health system; and, stakeholder outreach in support of ministry innovation priorities.

Health Workforce Planning and Accountability Division – oversees provincial health workforce policies and regulations, provider compensation, health provider major agreements, and the governance and administration of the Alberta Medical Association Agreement. The division works in close collaboration with key stakeholders, including physicians, professional colleges and associations, and other partners, both internal and external to the Government of Alberta, to design and administer evidence-informed, value-oriented policies and health benefits that serve the needs of all Albertans.

Pharmaceutical and Supplementary Benefits Division – oversees the governance and administration of the Alberta Health Care Insurance Program, remuneration systems and claims processing for physicians and allied health professionals, and interprovincial reciprocal financial arrangements. The division designs and delivers community-based supplementary health benefit programs on behalf of Albertans requiring pharmaceutical, chiropractic, optical, dental, and other medical supports (wheelchairs, prosthetics, oxygen, medical/surgical supplies, etc.). The division also provides leadership to national and provincial organizations to ensure accountable and appropriate delivery of blood, organ and tissue donation, dialysis and other provincial clinical services.

Health Standards, Quality and Performance Division – leads the evidence-informed development, negotiation, monitoring and renewal of health service guidelines and standards, and provides leadership in quality enhancement and long-range health system planning activities. The division includes responsibility for the ministry's analytics and data management functions to enhance system reporting and performance management, as well as health economics and funding capacity to support the cost effective application of standards and quality setting functions across the system.

Health Service Delivery Division – is responsible for the implementation of a community-based, health care service delivery integration plan to advance a shift to enhanced community care. This includes the integration and co-ordination of health services in the areas of primary and community care, continuing care, addiction and mental health, emergency health, and in support of Indigenous people and communities. The division works closely with partners to plan across other social-facing ministries, and national and provincial governments and organizations.

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Office of the Chief Medical Officer of Health – provides leadership and public health expertise on all issues of public health importance such as health surveillance, population health, and injury or disease control initiatives. This includes taking necessary measures to respond to new and emerging pathogens, control and intervention programs to limit the spread of communicable diseases, infection prevention and control measures, and health risk assessments. The Chief Medical Officer of Health has overarching legislated responsibilities for monitoring and reporting on the health of Albertans and intervening to protect and promote the health of the public under authority of the *Public Health Act*. This is accomplished by the office supporting and sometimes leading the development of healthy public policy and fulfilling the obligations under the Act.

Communications – provides Albertans and health system partners with information about ministry policies, programs, and initiatives. The branch works with department staff to develop and implement communications plans and offers communications support, such as media relations, issues management, writing and editing services, product development, and online communications services. The branch also works closely with Alberta Health Services and other reporting entities to co-ordinate ministry communications.

Strategic Coordination and Operations Team – acts as a hub to manage the operations of the ministry and support the corporate processes that develop and deliver the ministry's priorities and daily work. The team's responsibilities include: leadership and co-ordination of the ministry's policy, planning and reporting; planning and co-ordinating the delivery of ministry policy and funding initiatives; Indigenous health policy; strategic support on federal/provincial/territorial health issues; Alberta Health Services accountability and relations with the department; governance of health sector public bodies; the provision of clinical expertise; human resources services; legal and legislative review services; ministry correspondence services; and, the ministry's response to applications under Alberta's *Freedom of Information and Protection of Privacy Act*.

Office of the Alberta Health Advocates – includes the Health Advocate and the Mental Health Patient Advocate. The office supports Albertans in resolving their health-related concerns by helping them navigate the health care system; referring individuals to the appropriate complaints resolution services; providing information about the Alberta Health Charter; requesting the inspection of provincial health care facilities; and, addressing patients' issues and concerns in relation to the *Mental Health Act*.

Health's 2016-19 Business Plan sets out four outcomes to guide the ministry's activities:

- Improved health outcomes for all Albertans.
- The well-being of Albertans is supported through population initiatives.
- Albertans receive care from highly skilled health care providers and teams, working to their full scope of practice.
- A high quality, stable, accountable and sustainable health system.

These outcomes are supported by key strategies, performance measures and performance indicators, all of which are aligned with the strategic direction of the government and inform policies, programs and services provided by the ministry.

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As part of its planning process, the Ministry of Health must consider strategic risks that can have an overarching effect on its ability to meet its mandate, mission and long-term outcomes. Health's 2016-19 Business Plan identified the following risks in this context and an update on their status is provided below:

Socioeconomic diversity: Despite high per capita spending on health care, performance results suggest Alberta's health care system is not providing correspondingly high quality care nor improved population well-being. An aging population, the prevalence of complex chronic diseases, inequalities in health outcomes and access to services, siloed service delivery, and growing costs continue to challenge the sustainability of the system. Efforts to better integrate health programs and services, align them with Albertans' needs, and to bend the cost curve on three high-cost areas (physicians, hospitals, and drugs) must continue if the health system is to meet Albertans' health needs over the longer term.

Changing health care delivery: Alberta's health care system remains hospital-based and treatment-focused and shifting the system to emphasize care in the community is a complex task. Positive results will take time to realize as there are significant challenges and trade-offs that must be managed as changes are implemented. The right number, mix and distribution of health providers are needed to align with overall health system planning and the needs of Albertans. Continued focus on the development and use of integrated health information technology systems is critical to support collaborative, team-based care, support population health and ensure Albertans have the tools to support their own health.

Timeliness of policy development: The development of government policy is complex as it must consider not only current challenges but also ensure it does not create further issues in the future. Robust government policy must be evidence-informed, must be flexible enough to adjust to a dynamic external context, and consider the perspectives of a range of stakeholders. Engagement and the development of relationships with affected stakeholders is key to securing commitment to responding to identified challenges in a measured, structured and timely manner.

Emergency preparedness: The risk of an event that could impact Alberta's health system always exists, whether it is a health scare (e.g., disease outbreak, etc.), cyber-security attack or other such event. Effective emergency response requires significant advance planning and preparation, well-developed communications protocols, and robust data sets upon which decisions can be based. Continued investment in robust surveillance systems and health analytics is required to not only respond to an emergency event, but also to anticipate and better plan for an effective response.

Government influence on population health: A healthy society is one that has the principles and concepts of health and the social determinants of health woven throughout its institutions. Many of the social determinants of health fall outside the health system and must be addressed by developing partnerships across communities, government and organizations to create the conditions for good health, ultimately reducing the demand for acute care services. Increased co-ordination of services and supports throughout society is needed to support Albertans in making healthy choices and creating healthy urban and rural environments. Enablers include innovation and technology, data and information sharing, and community engagement in planning of health services.

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Results Analysis

Discussion and Analysis of Results

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Results Analysis

Discussion and Analysis of Results

Introduction

The Government of Alberta is committed to a stable, accountable, high quality and sustainable health system that emphasizes staying healthy and well, while also supporting people who need care. It's a vision where Albertans' health and well-being are improved through an integrated health system that is structured around individuals and their communities and connects people to needed care and services. The goal is for Albertans to receive the right health care, in the right place, at the right time, by the right health professionals, with the right information.

Achievement of this government vision requires a shift away from a health system focused on hospitals and facilities toward a more community-based system grounded in a collaborative, team-based approach to health and health care, and centred on individuals. Further, with Alberta either at or near the top for health spending across the country, the need to focus on controlling the three biggest cost drivers of health care – physician compensation, hospital services and pharmaceuticals – is paramount if the system is to be sustainable.

In 2016-17, government undertook a number of initiatives to support enhanced care in the community, improve population health outcomes, and create a more fiscally sustainable health system. Some of these are:

Community Based Health: Increased funding for home care; action to support comprehensive, integrated, team-based primary health care service delivery; and, expansion of paramedics' scope of practice, allowing them to safely care for patients in their homes and reduce the number of patients transported to hospital.

Population Health: Passed the *Public Health Amendment Act*, which increases government's ability to respond quickly to vaccine-preventable outbreaks in schools by facilitating more efficient collection of student enrolment information to help identify students with incomplete immunization records; and, requiring parents to either complete or update missing immunizations, provide a letter indicating a medical exemption has been granted, or sign a form indicating they choose not to immunize their child and understand they will be required to keep their children home if certain highly contagious vaccine-preventable diseases such as measles occur at their school.

Responsible Fiscal Management: Signed an amending agreement with the Alberta Medical Association that is expected to save up to $500 million in public funding over the next two years. The agreement moderates health care expenditure growth and provides for collaboration and shared responsibility on a number of initiatives aimed at improving the health system for Albertans.

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Challenges: Government faced some key challenges in 2016-17 which impacted the health care system. The Horse River Wildfire in Fort McMurray tasked multiple ministries to respond quickly and will continue to require dedicated resources to support the Regional Municipality of Wood Buffalo in the recovery. The Department of Health and Alberta Health Services led the health-related response, including evacuating patients from the Northern Lights Regional Health Centre, increasing mental health and addictions supports for affected members of the community, and ensuring ground water, soil and air quality were all at safe levels before permitting residents to return home.

The ongoing opioid crisis remained a challenge, with fentanyl, carfentanil and other dangerous substances continuing to cause harm, to both individuals and their families. Government took action to address the need for stronger supports for Albertans struggling with addictions by implementing a range of tools to address overdoses and deaths related to opioids. This included providing increased access to naloxone kits to reverse overdoses, opening new treatment spaces, supporting applications to establish supervised consumption sites, and working with the College of Physicians and Surgeons of Alberta to support appropriate opioid prescribing. The opioid crisis will require continued support from the government going forward.

Key Strategies and Initiatives: During 2016-17, the ministry moved forward on a number of key strategies and initiatives to better align health services with the needs and expectations of Albertans, such as:

- Improving addiction and mental health system services with particular consideration given to priority populations (children, youth and families; people with multiple and complex needs; people with addictions; and, Indigenous people and communities), as per the recommendations from the *Valuing Mental Health Report*.
- Implementing a number of measures to support the evidence-informed and effective use of prescription drugs on government drug plans and changes to the coverage of some medication groups, such as stomach acid management drugs, which will save taxpayers $40 million alone over three years.
- Approving a Medical Assistance in Dying framework that protects the vulnerable while supporting individuals who want to exercise their rights, including establishing an AHS care co-ordination service to provide information, resources and support to patients, families and providers on medical assistance in dying and end of life care options.
- Expanding the Dementia Advice service province-wide through Health Link (811), providing callers with access to specially trained dementia nurses who are able to provide information on clinical issues that occur during the course of dementia.
- Proposing the *Emergency Health Services (Ground Ambulance) Regulation*, which will consolidate and update existing regulations to encompass new modes of delivering EMS such as paramedic response units, community paramedicine and the use of vans for non-urgent patient transports.
- Granting access to Alberta Netcare for optometrists and dentists, allowing more care providers to have electronic health record information at their disposal to provide better informed care.
- Passing the *Voluntary Blood Donations Act* which prevents private clinics that pay donors for their blood donations from setting up in the province and ensures that our blood system continues to be strengthened as a public resource.
- Committing a total of $251.9 million to continue 27 approved health facilities projects, and programs to repair aging infrastructure and/or build new health infrastructure.

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- Launching a three-year, Nurse Practitioner Demonstration Project, which supports the integration and increased use of nurse practitioners and other providers in the community, particularly in areas that serve vulnerable, high-need populations.

The following information provides details about the ministry's progress and achievements in responding to the desired outcomes set out in the 2016-19 Health Business Plan.

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DESIRED OUTCOME ONE: Improved health outcomes for all Albertans.

Achievements

(1.1) Introduce an expanded model for home and community care which will increase access and the variety of services available to Albertans

In March 2017, Alberta signed a new 10-year Health Accord funding agreement with the federal government that included an increased focus on home and community care. As part of this agreement, the Government of Alberta will receive $703.2 million to identify areas of focus for expanding home and community care services to address gaps in service and to expand and spread innovative practices across the province.

The Department of Health has been working closely with Alberta Health Services (AHS) to address the increasing demand for home care services as well as discrepancies in the amount and types of services available across the province. Even with increased investments to the home and community care budget, AHS was challenged to meet the demand for services. In order to achieve the vision of community-based care, Budget 2017 announced an additional $200 million investment in home care and community care services.

The department continued to support implementation of AHS' Provincial Framework for palliative and end of life care (PEOLC). The framework identifies the benefits of increasing community capacity to expand PEOLC into primary care settings. Primary care providers can address palliative needs earlier, leading to reduced emergency department and acute care admissions.

In June 2016, the Government of Alberta implemented a provincial framework for Medical Assistance in Dying (MAID) following consultation with a range of stakeholders, including AHS, and input from the public. The framework sets out standards of practice for physicians and nurse practitioners, directs AHS to establish a MAID Care Coordination Service, and establishes a MAID Regulatory Review Committee. The department, AHS, the College of Physicians and Surgeons of Alberta, and other health professional colleges continue to collaborate on a regulatory framework that is consistent with the Supreme Court of Canada's February 2015 ruling.

The AHS Care Coordination Service is unique among many provinces and territories, in that it provides one point of access for Albertans and providers to get more information about MAID and receive support in finding physicians or nurse practitioners willing to administer services. It also supports data collection and reporting. As of March 27, 2017, 103 people had received medical assistance in dying in Alberta.

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(1.2) Create 2,000 public long-term care and dementia spaces over four years to assist seniors and persons with disabilities to remain in their communities when they can no longer live at home and thereby take pressure off acute care systems

The Department of Health continues to work with AHS and third party providers to establish 2,000 long-term care and dementia spaces. The ministry, including AHS, is also working with other key ministries to determine the most appropriate locations for new continuing care spaces, and to ensure that new spaces meet the assessed needs of Albertans. These spaces will support Albertans to remain in their communities as they age or their care needs change.

During 2016-17, government announced funding to support the development of new continuing care spaces in several locations, including:

- 99 long-term care spaces in Edmonton on the grounds of Villa Marguerite;
- 128 long-term care spaces and 224 dementia spaces in Calgary at the AgeCare SkyPointe community (an increase from what was originally funded);
- 78 long-term care spaces in Calgary at Wing Kei Greenview; and
- 26 new long-term care and designated supporting living spaces at the Edson Healthcare Centre.

(1.3) Implement an addiction and mental health strategy

In February 2016, *Valuing Mental Health: Report of the Alberta Mental Health Review Committee* was released following extensive consultations with Albertans through an online survey and public meetings. To achieve the transformational change that the report calls for, stakeholders recommended that proposed actions focus on improving system continuity through co-ordinating and integrating services across the health system and with community service providers, and supporting those who are most likely to experience vulnerabilities. Stakeholders recognized that while actions in response to the report must serve all Albertans, particular focus should be given to groups who are underserved including: children, youth and families; people with multiple and complex needs; people with addictions; and Indigenous people and communities.

A number of actions have been taken, in addition to the initial six accepted recommendations, including:

- funding of $750,000 over three years to the Calgary Recovery Task Force to improve supports for vulnerable people with addiction and mental health issues in downtown Calgary;
- funding of $300,000 to the Camrose Primary Care Network to develop and implement a youth hub providing increased access to addiction and mental health supports;
- funding of $400,000 to the Zebra Child Protection Centre Society to increase service access for children who have experienced sexual abuse; and,
- funding of $100,000 each, provided to the Métis Settlements General Council, the Métis Nation of Alberta Association, and Aseniwuche Winewak Nation, to develop culturally appropriate opioid response plans for their communities.

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An implementation structure has been established to engage government, AHS, and community stakeholders to develop and steward a plan to respond to the *Valuing Mental Health* report, including extensive stakeholder consultation. For example, in May and October 2016 and January 2017, ministry staff met with approximately 100 representatives from government, community, and AHS to provide an update on the implementation progress and solicit input and feedback on the next steps.

One common theme arising from the work of the Mental Health Review Committee was the need for stronger supports for Albertans struggling with addiction. The opioid crisis affecting Albertans of all walks of life was a significant challenge faced by the ministry in 2016-17. The provincial response to the opioid crisis was intensified in the fall of 2016 due to continued increases in the number of opioid-apparent overdose deaths (including opioids such as fentanyl and carfentanil). Financial resources were re-allocated to accelerate actions to reduce the harms associated with opioids.

In 2016-17 the province spent $26.5 million on measures to address the opioid crisis. Highlighted achievements include:

- multiple grants executed to: distribute almost 15,000 naloxone kits from over 1,000 locations to Albertans (naloxone can save lives when given immediately following an overdose and followed up with emergency medical support); expand opioid dependency treatment; expedite exemption applications to provide supervised consumption services in Edmonton and Calgary; roll out short-term public education campaigns; and, engage primary care stakeholders in a Planning Summit for Opioid Dependency Maintenance and increase their role in addressing opioid dependence;
- Ministerial Orders and legislative changes issued to enhance access to and administration of naloxone across the province;
- continued evaluation and improvement of the take home naloxone program;
- working with the College of Physicians and Surgeons of Alberta to support appropriate opioid prescribing; and,
- publication of quarterly and interim Opioid and Substances of Misuse Reports, a direct result of the ministry's relationship with the Office of the Chief Medical Examiner.

Despite efforts and progress in several areas, the rate of overdose deaths remains high. Substance use and addictions are complex health and societal issues requiring integrated action on many fronts.

(1.4) Enhance the delivery of primary health care services to enable Albertans to be as healthy as they can be through increased integration of services, improved capacity, timely access and improved quality and safety

Primary health care is the first place people go for health care or wellness advice and programs, treatment of a health issue or injury, or to diagnose and manage a health condition. Primary health care draws on the expertise of many different providers working together to support people and their families. Primary health care may include a visit to a family doctor, a consultation with a nurse practitioner, advice from a pharmacist or an appointment with a dietitian or therapist.

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In July 2016, the ministry publicly released the Primary Care Network (PCN) Review, which involved an analysis of the financial practices and service delivery approaches of a sample of 13 PCNs and the Primary Care Network Program Management Office. Actions undertaken as a result of the review include development and implementation of a PCN Policy to strengthen governance, financial accountability and service responsibilities in order to support comprehensive, integrated, team-based primary health care service delivery.

(1.5) Improve the quality of care provided to continuing care clients and improve care and supports needed by Albertans living with and affected by dementia

In 2016-17, the ministry provided funding to several initiatives supporting Albertans living with dementia. For example, funding was provided to the Alzheimer Society of Alberta and Northwest Territories to expand its First Link® program to Calgary, adding to previous investments that enabled the initial implementation of First Link® in five other major cities across the province. First Link® is a post-diagnosis referral program that connects newly diagnosed Albertans and their families and caregivers to learning, services and resources as early as possible in the disease process, enabling them to better navigate living with dementia and finding support along the way.

Other examples include the development and province-wide expansion of Dementia Advice through Health Link (811). Dementia Advice provides 811 callers with access to specially trained dementia nurses who are able to provide information on clinical issues that occur during the course of dementia. Since the program went province-wide on May 30, 2016, there have been more than 1,000 referrals provided from 811 to Dementia Advice.

The ministry also supported innovation projects designed to improve quality of life for people impacted by dementia, such as Person-Centred Art Therapy for People with Dementia with The Alzheimer Society of Calgary and Moving for Memory with the Edmonton Southside Primary Care Network, and the Appropriate Use of Antipsychotics Initiative, which was designed to reduce the inappropriate use of antipsychotics (defined as use of an antipsychotic without a diagnosis of psychosis) in long-term care facilities. Since its inception, the inappropriate use of antipsychotics within long-term care has dropped significantly to just 18.1 per cent as of the end of 2015-16, well below the national average of 23.9 per cent. Building on this success, the ministry is supporting the expansion of the initiative to designated supportive living facilities by June 2018.

The updated Continuing Care Health Service Standards came into effect on April 1, 2016, and the department and AHS have worked collaboratively with continuing care operators to implement and evaluate the updated standards. Stakeholders have generally been positive about the changes that have come about with the updated standards, citing the impact they have had on the provision of client-centered care, client safety and the use of a multi-disciplinary, collaborative team-based practice approach to planning care. Stakeholders have, however, also noted a small number of specific requirements that need to be strengthened to improve clarity and to support the achievement of the standards as intended. These improvements are in progress.

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The ministry is continuing its review of continuing care-related legislation including the *Nursing Homes Operation Regulation*, *Nursing Homes General Regulation*, *Co-ordinated Home Care Program Regulation* and the *Supportive Living Accommodation Licensing Regulation*. In support of the review and update of these regulations, over 4,000 Albertans have participated in public engagement through in-person discussion sessions and online surveys. The feedback gathered will assist the ministry with ensuring the updates reflect the needs and desires of Albertans.

(1.6) Improve the effectiveness and efficiency of emergency and ambulance services

Ensuring Albertans have the best possible access to Emergency Medical Services (EMS) is critical and the department is working closely with AHS to improve the availability and quality of EMS services across the province.

In early 2017, the priority of consolidating EMS dispatch progressed with AHS moving 77 communities in southern Alberta into the AHS Southern Communications Centre. This move aligns with a 2013 recommendation from the HQCA and allows for the highest degree of integration of EMS dispatch for these communities. Consolidating dispatch allows AHS to send the closest ambulance to emergent medical calls, further bolstering Alberta's borderless EMS system.

EMS practitioners operate in unique circumstances relative to other health care providers and have an increased chance of suffering from post-traumatic stress. The department has worked with AHS to establish an EMS Psychological Health and Safety Advisory Committee made up of frontline paramedics and ministry leadership to bring forward recommendations to improve mental health programs for EMS staff. The committee surveyed frontline paramedics and found they would like more psychological supports aimed at increasing resiliency in the workplace. AHS continues to implement the committee's recommendations, in part by deploying psychologists within EMS.

(1.7) Enhance and expand electronic health records to support clinical decision-making and provide additional resources and tools through the personal health portal to assist Albertans in taking an active role in managing their health

Alberta Netcare is the name for all the projects and activities related to the provincial Electronic Health Record - a secure and confidential electronic system of Alberta patient health information, including dispensed medications, laboratory test results, diagnostic images, and hospital reports. In June 2016, immunization information was made available in Alberta Netcare.

By March 31, 2017, the actual number of healthcare professionals (physicians, physician residents, nurses, pharmacists, optometrists, dentists, chiropractors, and allied health professionals) with access to Alberta Netcare was 42,090 – significantly more than the target of 41,149 for 2016-17. Optometrists and dentists were granted access to Alberta Netcare in 2016-17, allowing more care providers to have electronic health record information at their disposal to provide better informed care.

More than 80 per cent of Alberta's community physicians and specialists use an Electronic Medical Record (EMR) system and that information is not shared with other providers. In 2016-17, the department began building the Community Information Integration project which will allow 78 data elements from these EMRs to be shared through Alberta Netcare.

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During 2016-17, the department also issued a Request for Proposals for a vendor to provide a new platform for the Personal Health Record (PHR). The existing PHR platform is no longer supported by the original vendor and must be replaced. The department also continued to work with AHS to add immunizations and laboratory test results to the PHR, to make more of the provincial information available to the PHR, and to gradually increase the number of test users.

Following a May 2016 report on diagnostic lab services by the Health Quality Council of Alberta (HQCA), the government, AHS and the HQCA began the planning process for developing and implementing an integrated laboratory services system for the province. An integrated system ensures lab services needs are met in rural and urban Alberta, and facilitates better standardization, integration and capacity building for lab services. Budget 2016 included $2 million for planning and addressing immediate facility needs in the Edmonton area.

(1.8) Address rates of chronic disease in the province through disease prevention and health promotion initiatives

Through funding from the Alberta Cancer Prevention Legacy Fund, the department supported AHS in developing community cancer profiles which are online, interactive data sets presenting user-friendly community information on cancer, chronic disease and associated risk factors. These profiles, located at www.albertapreventscancer.ca, provide information on the status of Albertans at small geographic levels. This information is useful for planning and evaluation of public health, primary health care and chronic disease prevention programs.

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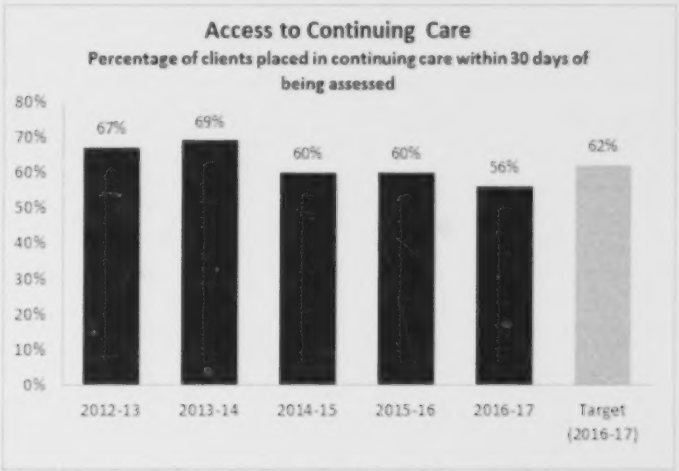
Performance Measures and Indicators

Performance Measure 1.a **Access to continuing care: Percentage of clients placed in continuing care within 30 days of being assessed**

This measure is used to monitor and report on access to continuing care living options in Alberta, as indicated by the wait times experienced by individuals admitted within the reporting period. Continuing care living option refers to the level of care in a publicly funded resident accommodation that provides health and support services appropriate to meet the client's assessed unmet needs (i.e., Designated Supportive Living Level 3, 4, 4-Dementia, or Long-Term Care).

Results Analysis

A number of factors have contributed to this year's lower than targeted result, including an ongoing need for capacity expansion due to an aging population as well as some unanticipated continuing care capacity and facility issues that arose in 2016-17. These challenges have driven longer waits and higher waitlists for placement into continuing care living options.



Source: Alberta Health Services, 7 Meditech rings for the South, Central and North Zones and from 2 Strata Health Pathways applications by the Calgary and Edmonton Zones.

To continue to address the broader capacity expansion need, the Government of Alberta is committed to increasing capacity for publicly funded, facility-based continuing care (which includes long-term care and designated supporting living) by increasing funding for new spaces. Capacity issues are expected to be partly addressed when the planned spaces start to become available in the coming years. Also critical will be an expansion of home care services that enable people to stay at home longer. A significant increase to home and community care funding was announced in Budget 2017.

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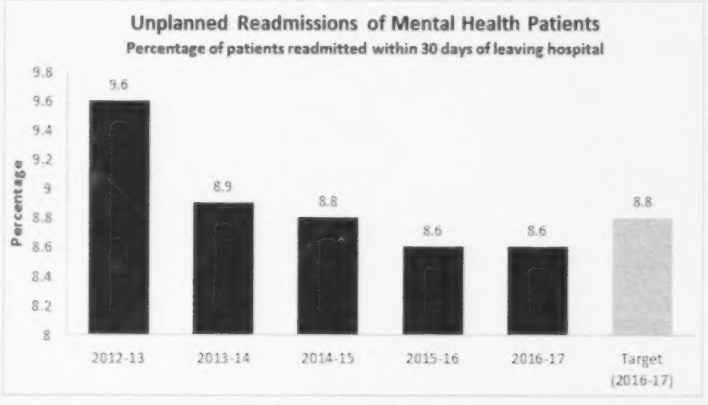
Performance Measure 1.b **Percentage of mental health patients with unplanned readmissions within 30 days of leaving hospital**

This measure represents the proportion of occurrences of a non-elective (unplanned) readmission to an acute care hospital for selected mental illness within 30 days of a patient being discharged from the index hospital stay for which the most responsible diagnosis was selected mental illness. This measure is reported a quarter later due to the requirement to follow up with patients after the end of the reporting quarter. The measure applies only to inpatients of acute care hospitals in Alberta. Visits to facilities and programs not designated as acute inpatient care facilities are not included (e.g., emergency departments, urgent care centres, community clinics).

Results Analysis

As of the third quarter of 2016-17 (December 31), 8.6 per cent of mental health patients experienced an unplanned readmission within 30 days of leaving hospital. This is consistent with the third quarter of 2015-16 (8.6 per cent) and lower than the target of 8.8 per cent which means that fewer mental health patients had to be readmitted due to complications arising from previous discharges, other non-related circumstances, accidents, etc. This result supports the gradual downward trend in unplanned readmissions from a high of 9.6 per cent in 2012-13.



Source: Canadian Institute for Health Information (CIHI); Alberta Health Services, Provincial Inpatient Database (DAD).
Note: 2016-17: 8.6% at end of Q3 (December 31). This measure is reported a quarter later due to the requirement to follow up with patients after the end of the reporting quarter.

Alberta Health Services will continue the use of Community Treatment Orders as one method to reduce readmission rates for patients with severe and persistent mental health problems. Other initiatives include the opening of the Mental Health Assessment Unit at Rockyview General Hospital in Calgary, implementing a Youth Mental Health Day Program in the North Zone, and piloting an Adult Acute Transition Clinic at Alberta Hospital Edmonton.

Challenges in recruiting in smaller rural and remote communities, combined with demand for services, means accessing community mental health services can be difficult for Albertans living outside major centres. In the North Zone, results were impacted due to the temporary closure of the Northern Lights Regional Health Centre during the Horse River Wildfire. In the Calgary and Edmonton Zones, there continues to be high demand on all addiction and mental health services. This demonstrates the need for continued investment in mental health services for Albertans.

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Performance Measure 1.c **Access to the provincial Electronic Health Record (EHR): Number of health care professionals with access to EHR**

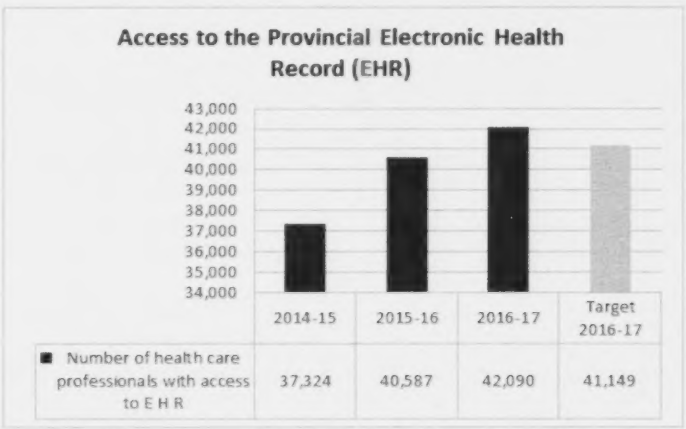
Information is foundational to support evidence-informed health care delivery, policy development and decision-making. In order to transform the health system, access to health information from providers, facilities and patients is needed to improve health service delivery.

Alberta Netcare is the name for all the projects related to the provincial EHR, a secure and confidential electronic system of Alberta patients' health information. The portal enables both the public and health care providers (registered users) to access available health information, with new content continually being added.

Results Analysis

There was a consistent increase of clinicians' access to Alberta Netcare in 2016-17. This is the result of continued demand for Netcare, ongoing support of the eHealth Support Services team and the completion of needed work to deploy Netcare access to three additional professions (optometrists, chiropractors and dentists) for 2017-18.

The 2016-17 target of 41,149 is based on the previous annual rate of health care professionals obtaining access to Alberta Netcare and the continued dedication of eHealth support services resources designated to support the adoption of Alberta Netcare. To date, the average annual rate of increased access has been five per cent. As the three additional professions come on board in higher numbers, the increase in the overall average adoption rate is expected to increase to six per cent in 2017-18 and 2018-19.



Source: Alberta Netcare Monthly Utilization Report

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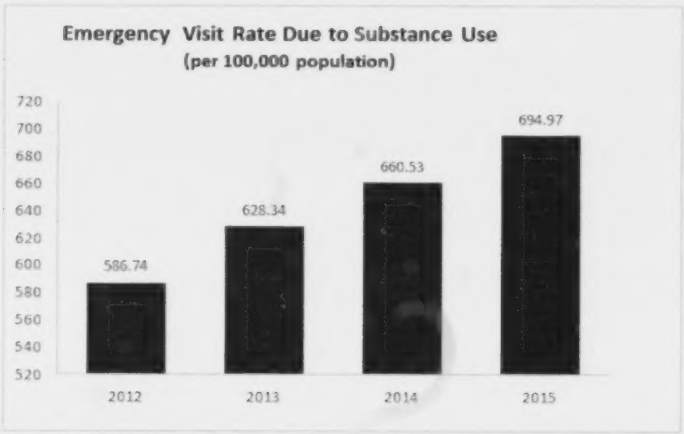
Performance Indicator 1.a **Emergency visit rate due to substance abuse (per 100,000 population)**

This indicator provides the age-standardized rate of visits to emergency departments and urgent care centres related to substance use and misuse. In addition to emergency visits due to psychoactive substance use, this indicator includes visits due to use of alcohol or non-psychoactive substances.

Results Analysis

Alcohol and substance misuse results in significant disability, morbidity, and death in Alberta each year. Psychoactive substance use can lead to dependence syndrome – a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state.



Source: Alberta Ambulatory Care Database, Alberta Health Care Insurance Plan, Mid-year adjusted Population Registry Files, Statistics Canada Canadian population, 2011.
Note: 2016 results for this indicator were not available at the time of this publication.

The age-standardized rate at which Albertans have visited emergency departments with diagnoses related to mental and behavioral disorders due to substance use has increased an average of 5.8 per cent annually from 2012 to 2015. The increase in the availability of illicit opioids (particularly fentanyl) continues to contribute significantly to the increase in emergency visits due to psychoactive substance use.

Policies which influence the levels and patterns of substance use and related harm can significantly reduce the public health problems attributable to substance use, and interventions at the health care system level can work towards the restoration of health in affected individuals. The Ministry of Health provides a variety of addiction and substance use resources online at www.health.alberta.ca/health-info/AMH-Addiction-Substance.html.

In May 2017, the Government of Alberta established the Minister's Opioid Emergency Response Commission under the *Public Health Act* with a mandate to implement co-ordinated actions to address the opioid crisis.

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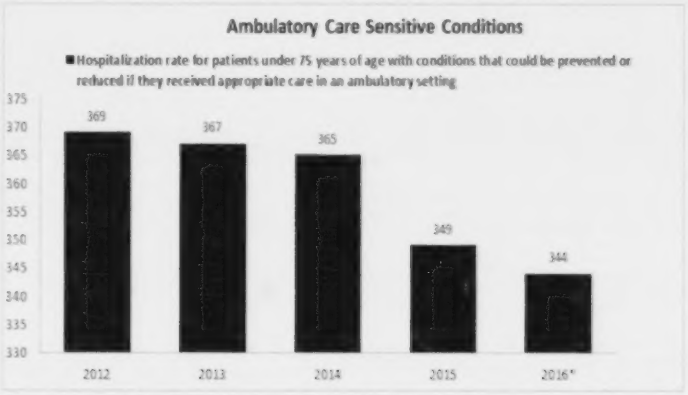
Performance Indicator 1.b **Ambulatory sensitive care conditions: Hospitalization rate for patients under 75 years of age with conditions that could be prevented or reduced if they received appropriate care in an ambulatory setting**

This indicator measures the number of people (under 75 years of age) per 100,000 population who were hospitalized for health conditions that could have been treated in an ambulatory care setting. The ambulatory care sensitive conditions for this indicator include: grand mal status and other epileptic convulsions; chronic obstructive pulmonary diseases; asthma; heart failure and pulmonary edema; hypertension; angina; and, diabetes.

Ambulatory care is provided outside of a hospital inpatient setting, such as in community clinics operated by Alberta Health Services, urgent care centres, and emergency departments. Hospitalization for an ambulatory care sensitive condition is considered an indicator of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition.

Results Analysis

Appropriate management and control of chronic conditions in the community has the potential to reduce the need for hospitalization, improve efficiency in resource utilization and, in turn, reduce total health spending associated with the treatment of chronic illnesses.



Source: Numerator: Discharge Abstract Database. Canadian Institute for Health Information
Denominator: Statistics Canada post-censal population estimate (based on 2011 population).
* Note: 2016 results (344) are preliminary results.

Since their inception in 2005, Primary Care Networks (PCNs) have provided programs such as hypertension prevention and control, diabetes education and management, and asthma education and management. The declining hospitalization rate for patients with ambulatory care sensitive conditions may, in part, be attributed to the maturation and broader programming and supports of PCNs, including after-hours clinics.

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DESIRED OUTCOME TWO: The well-being of Albertans is supported through population health initiatives

Achievements

(2.1) Strengthen policies and practices to protect environmental public health, based on environmental public health science and international best practices

The Department of Health used established principles and best practices to guide its actions and advice regarding the response, re-entry and recovery associated with the Horse River Wildfire (Fort McMurray) to protect residents of the Regional Municipality of Wood Buffalo from environmental public health risks. This included evaluating available environmental monitoring data, deploying additional environmental monitoring, and collaborating with other government ministries and partners such as Alberta Health Services (AHS), the Alberta Energy Regulator, and the federal government. A significant number of technical and plain language assessments of the immediate health risks to returning residents were developed and published on the Government of Alberta Wildfire website.

The department also published technical assessments related to food, water, odours, and human health protective action criteria for air quality (www.health.alberta.ca/newsroom/pub-environmental-health.html) and finalized the development of a clinical practice guideline related to emissions from the oil and gas industry. In addition, three environmental public health data sets were released to Open Data Alberta in 2016-17.

Engagement with First Nations and Metis stakeholders increased in 2016-17 with the public release of the Recurrent Human Health Complaints Technical Synthesis for Fort McKay, which can be found online at www.aer.ca/documents/reports/FortMcKay_FINAL.pdf and the establishment of an advisory committee to implement the recommendations of this report with government, industry and community partners. Engagement with the community of Fort Chipewyan to develop an approach to support human health and reduce incidence of cancer is also underway.

(2.2) Modernize the food safety inspection system in partnership with Alberta Health Services and other government ministries

The Department of Health is responsible for the administration of the *Public Health Act* and *Food Regulation*. Enforcement of the *Food Regulation* is the responsibility of AHS through its inspection programs. Alberta Agriculture and Forestry administers and enforces acts and regulations (such as the *Meat Inspection Act*) that support inspections of slaughter and associated meat processing facilities.

The Department of Health, AHS and Alberta Agriculture and Forestry are working together to strengthen the province's food safety system, throughout the supply chain, to better protect the public from food borne illness.

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(2.3) Develop a whole-of-government approach to wellness and collaborate with key partners to build community capacity in support of wellness

The Department of Health supports the well-being of Albertans through the development and monitoring of population-based public health policies and investment in health initiatives that support Albertans in making healthy choices in their lives. These activities are undertaken in collaboration with other ministries, AHS, communities, and a variety of stakeholders to foster integrated approaches to public health and wellness.

The Health in All Policies analysis process and toolkit, which encourages Government of Alberta policy practitioners to take the social determinants of health into account when developing and evaluating public policy, was introduced to several cross-government partners. As many of the social determinants of health are influenced by policies, strategies, and legislation of ministries across the Government of Alberta, supporting the development of more holistic public policy will help improve population health outcomes and reduce health inequities.

Through support from the Department of Health, the Communities ChooseWell program helped 260 communities support healthy eating, active living, and social inclusion through programs, policy and supportive social and physical environments. A sample of 67 participating communities reported on the program's impact, as follows: community-wide knowledge of healthy eating and active living was increased (91 per cent); capacity and skills to improve health and wellness were improved (88 per cent); local partnerships for healthy living were strengthened (88 per cent); and, community health and wellness coalitions/committees were established (33 per cent).

Comprehensive School Health (CSH) is an internationally accepted strategic framework incorporating policies and practices that support educational outcomes and contribute to student health and wellness in every aspect of the broader school community. The Department of Health supports CSH and school wellness through collaboration with Ever Active Schools and the Alberta Healthy School Community Wellness Fund, which includes First Nation and Metis schools.

The Alberta Healthy School Community Wellness Fund supported 102 school community projects. Common strategies used to incorporate a wellness culture included building professional capacity in teachers, healthy relationship development, student involvement through student-led initiatives, and peer mentoring.

Ever Active Schools, a provincial initiative designed to assist school communities in addressing and creating healthy school communities, assisted staff to work directly with 1,100 school communities, including 55 First Nations and Metis schools in Alberta through innovative, community-driven projects, professional learning, and healthy school policy creation. Two significant achievements were: assisting the Kainai Board of Education to develop its Wellness Policy and supporting handbook, the first wellness policy created by an Indigenous school community in Canada; and, assisting the University of Calgary-Werklund School of Education's development of the Creating Healthy School Communities course. This course is the first in Canada to be a degree requirement and will be mandatory for all Bachelor of Education students at the University of Calgary, starting in winter 2018.

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Protection for Persons in Care (PPC) promotes abuse prevention and responds to reports of abuse of adult Albertans receiving care or support services from publicly funded service providers, such as hospitals, seniors' lodges, nursing homes, and other supportive living settings. In April 2016, the Department of Health began publicly posting PPC Decision Summaries on its website (www.health.alberta.ca/services/PPC-decision-summaries.html). Decision summaries report allegations of abuse, the director's decision of 'founded' or 'not founded' and directives issued to the service provider to address compliance and for prevention of possible future abuse. This is a significant step in educating the public about how service providers are responsible under legislation to prevent possible abuse, as well as demonstrating the ministry's commitment to transparency and to protecting the most vulnerable Albertans.

(2.4) Improve and protect the health of Albertans through a variety of strategies, including increased immunization rates

Influenza has a significant impact on the health of Albertans and tends to be most severe among older Albertans, residents of long-term care facilities, infants, young children, and those with certain chronic medical conditions. The ministry's annual influenza immunization campaign is an important population health initiative intended to decrease the risk of outbreaks, illness, and death among all Albertans.

In December 2016, the *Alberta Public Health Amendment Act* was passed, enabling more efficient collection of student enrolment information to help identify under-immunized students. This will support additional contacts for parents by public health professionals to facilitate and encourage updated immunization. Other related accomplishments during 2016-17 included adding immunization data from the provincial immunization repository to Alberta Netcare in near real time, thereby providing health care professionals with additional data to support clinical decision-making.

Alberta was the first province to offer the provincially funded Human Papillomavirus (HPV) vaccine. Gardasil® 9 vaccine replaced Gardasil® vaccine for all eligible individuals in September 2016. The Gardasil® 9 vaccine targets five additional cancer-causing types of HPV.

The Provincial Surveillance Initiative (PSI) System, Release 1.0, became operational at the end of March 2017. This is a real-time data collection system to protect citizens from the spread of communicable diseases. PSI Release 1.0 collects more than 80 per cent of communicable disease laboratory records in real time; this supports the early identification of communicable disease trends. Work to extend PSI's data collection to cover the remaining 20 per cent of laboratory records is planned over the coming months.

In April 2016, the ministry began Zika virus surveillance to monitor its impact on the health of Albertans. The Department of Health continues to monitor the latest national and international research on Zika virus and updates public health recommendations accordingly.

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In October 2016, the ministry began monitoring the circulation of enterovirus D68, a relatively new respiratory virus, and now routinely monitors the number of Albertans infected and the severity of illness. The Government of Alberta introduced and passed the *Voluntary Blood Donations Act*, which prevents private clinics that pay donors for their blood donations from setting up in the province. This legislation will help ensure that the province's blood system continues to be strengthened as a public resource. Banning paid blood donation will ensure Albertans are donating to the same co-ordinated, integrated blood supply.

(2.5) Reduce the health gap between Indigenous peoples and other Albertans by developing population health initiatives with federal and Indigenous communities

Significant gaps continue in the overall health status of Indigenous Albertans compared to non-Indigenous Albertans. Through early work that supports the United Nations Declaration on the Rights of Indigenous Peoples and the Calls to Action of the Truth and Reconciliation Commission, the Government of Alberta is addressing health challenges experienced by Alberta's First Nations and Metis populations.

The Government of Alberta and First Nations are establishing protocol agreements that provide a framework for continued collaboration. These protocol agreements are meant to function as a broad umbrella agreement, under which meaningful discussion, information sharing, and the exploration of issues of mutual concern can occur. The Treaty 8 Health Table is one of six tables that has been established under the *Protocol Agreement between Treaty 8 First Nations of Alberta and the Province of Alberta*, signed on April 26, 2016. Senior officials from the Ministry of Health and Treaty 8 have met several times to discuss priorities and develop work plans.

The department and AHS continue to be engaged at the trilateral Joint Action Health Plan table with Health Canada and Alberta First Nations from Treaty 6, 7, and 8. The objective of this table is to collaborate on initiatives to improve the health outcomes of First Nations people in Alberta.

The department collaborated with the Metis Nation of Alberta and the Metis Settlements General Council on a variety of Metis-led projects to enhance the access and compilation of Metis health data. The department is also supporting the Population, Public and Indigenous Health Strategic Clinical Network (SCN) which is engaged with AHS, external partners, community members, interest groups, municipalities, and community-based organizations to respond effectively to the public health needs of Albertans and address determinants of individual and community health and well-being.

(2.6) Collaborate with Agriculture and Forestry, Alberta Health Services and other stakeholders to develop and implement a strategy to address antimicrobial resistance through stewardship, surveillance, research, innovation and infection prevention and control

Antimicrobial resistance occurs when micro-organisms become resistant to drugs which were previously effective in killing or slowing its growth. A significant cause of antimicrobial resistance is from improper use of antimicrobials in humans as well as in animals, and spread of resistant strains between the two.

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Working with the ministries of Health and Agriculture and Forestry, the Alberta Veterinary Medical Association held the Alberta One-Health Antimicrobial Workshop in November 2016, bringing together experts in human and animal health to discuss antimicrobial resistance. The objective of the workshop was to facilitate collaborative discussion and identify issues and challenges faced by the various stakeholders as they refine, reduce and review current use of antimicrobials.

A provincial Antimicrobial Resistance Strategy that aligns with the work of Federal/Provincial/Territorial partners on the Pan-Canadian Framework for Action on Antimicrobial and Antimicrobial Use is under development.

(2.7) Implement a Wait Time Measurement and Waitlist Management Policy to address long wait times in the health care system

Albertans want transparent and standardized information about expected wait times so they can plan their lives, determine the best options for care, and easily navigate the health system. They also want assurance that wait lists are managed fairly. Clinicians want transparent and standardized information so they can best advise their patients and care for them, and easily find consultants available to take referrals. Administrators and government want transparent and standardized information about access and appropriateness so they can make better decisions regarding allocating resources where they are needed, and improve equity and safety for patients.

The Department of Health and AHS undertook foundational work to improve access to care and develop capability to better monitor and report on access to care. The department's Wait Time Measurement and Waitlist Management Policy work helped with the establishment of key wait time collection initiatives that will inform future wait time policy. This foundational work will be leveraged and incorporated into the future AHS Clinical Information System which will replace aging and obsolete information technology platforms across all AHS Zones.

Several other related department and AHS initiatives launched and continued in 2016-17, including https://myhealth.alberta.ca/, a website with valuable, easy-to-understand health information and tools made for Albertans; Strategic Clinical Networks, which are developing integrated care pathways; the re-launch of the Alberta Wait Time Reporting website (www.waittimes.alberta.ca); and AHS reporting of estimated wait times in Edmonton, Calgary and Red Deer emergency departments.

The department approved grant funding and continues to work with AHS on the Path to Care and eReferral initiatives. Path to Care continued to work with specialists/clinics to improve referral processes and ensure consistent measurement of referral information. Work was completed to modify the main scheduling systems used in the province to capture the appropriate wait time information for referrals.

Upgrades were completed to the Alberta Referral Directory, including a back-end database that will help monitor data accuracy and completeness. The directory will provide primary health care providers more information on available referral programs and specialists, as well as the expected wait time for referral. Work has progressed on the development of the Path to Care Scheduling Data Repository, which will be used to monitor and act upon wait time and other access key performance indicators. In October 2016, nephrology advice requests were added to eReferral.

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Integration of the Adult Coding Access Targets for Surgery and the Pediatric Canadian Access Targets for Surgery is underway to form the Alberta Coding Access Targets for Surgery (ACATS). The ACATS is an Alberta-developed, standardized coding system to help prioritize scheduled surgeries offered at facilities throughout the province, based on a patient's diagnosis and level of urgency. ACATS reports are available to surgeons and administrators to provide information on how long patients have been waiting in relation to their access target so wait lists for surgery can be managed more effectively. Optimization of ACATS continues in partnership with AHS zones and the Surgery Strategic Clinical Network.

(2.8) Develop and implement programs related to maternal, infant, child and youth health

Building on the provincial implementation plan developed in 2015-16, the department and AHS' collaboration on the Early Hearing Detection and Intervention program resulted in implementation plans for each zone. Screening devices were procured, and newborn hearing screening was launched in the Grey Nuns Hospital (Edmonton) neonatal intensive care and postpartum units.

In May 1, 2016, the department began providing expanded coverage for medically-required, specialized infant formula. Specialized infant formula can be costly (around $700 per month) and is sometimes necessary when an infant is unable to tolerate common infant formula because of a complex food allergy or a specific medical condition. This change makes these specialized, needed formulas more affordable for impacted families.

The department continues to support community organizations providing maternal-infant health-related initiatives that focus on reaching vulnerable populations and pilot innovative practices to improve maternal health and child health and development outcomes, including:

- Three programs in Edmonton, Red Deer and Calgary that support vulnerable, street-involved pregnant and parenting women to access health and social supports (health care, prenatal care, community resources, birth control, Child Intervention, housing, income support) to maintain sobriety, have healthy pregnancies and deliveries, and have the opportunity to safely parent their children.
- Two programs for pregnant and parenting teens to assist their improved health and wellbeing, and improve access to mental health services thereby reducing adverse childhood experiences for their children.
- Six First Nation Parent Child Assistance Programs that offer culturally sensitive, specialized and holistic support of pregnant women with alcohol and other health/social problems to improve birth outcomes and decrease risks of Fetal Alcohol Spectrum Disorder.

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Performance Measures and Indicators

Performance Measure 2.a **Influenza immunization: Percentage of Albertans who have received the recommended annual influenza immunization**

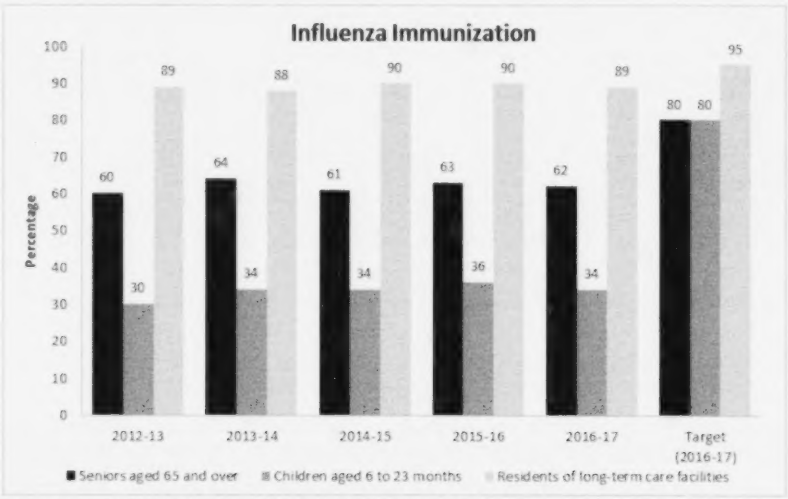
- **Seniors aged 65 and over**
- **Children aged 6 to 23 months**
- **Residents of long-term care facilities**

This performance measure tracks efforts towards immunization among high risk groups, including seniors (aged 65 and over), young children (aged six months to 23 months) and residents of long-term care facilities. Influenza immunization targets are set by the ministry in consultation with Alberta's Chief Medical Officer of Health and are based on national immunization targets as agreed to by the National Consensus Conference for Vaccine-Preventable Diseases in Canada in 2005.

Results Analysis

Rates of influenza immunization were predicted to be, and have remained, relatively consistent over the last few years.

The Government of Alberta continues to work with Alberta Health Services (AHS), pharmacists and physicians across Alberta to make access to influenza immunization easier and to communicate the importance and benefits of the annual influenza immunization program.



Source: Numerator: (count of those immunized by age category): AHS Zones; Alberta Blue Cross Pharmacy Billing Data; First Nations and Inuit Health, Alberta Region, Health Canada.
Denominator: Alberta's Interactive Health Data Application, Residents of Long-Term Care Facilities in Alberta

AHS also uses a number of specific strategies to increase influenza immunization rates for young children, such as more drop-in clinics (including day- and child-care centres), offering influenza immunization to children as they present for other routine childhood immunization, and targeted reminder calls and mail-outs. Parents have responded well to lunch-time and supper-hour clinics and reminders; however, this has not yet translated into improvements in overall immunization rates.

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Performance Measure 2.b **Childhood immunization rates (by age two)**

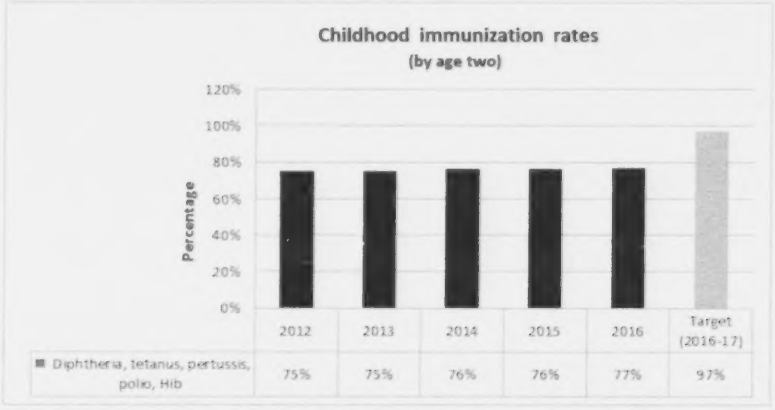
- **Diphtheria, tetanus, pertussis, polio, Hib**
- **Measles, mumps, rubella**

This measure indicates efforts towards protecting children from a number of vaccine-preventable diseases, some of which can be fatal or produce permanent disabilities. A high rate of immunization reduces the incidence of these diseases and also serves to control outbreaks. Targets are set by the ministry in consultation with Alberta's Chief Medical Officer of Health and are based on national immunization targets as agreed to by the National Consensus Conference for Vaccine-Preventable Diseases in Canada in 2005.

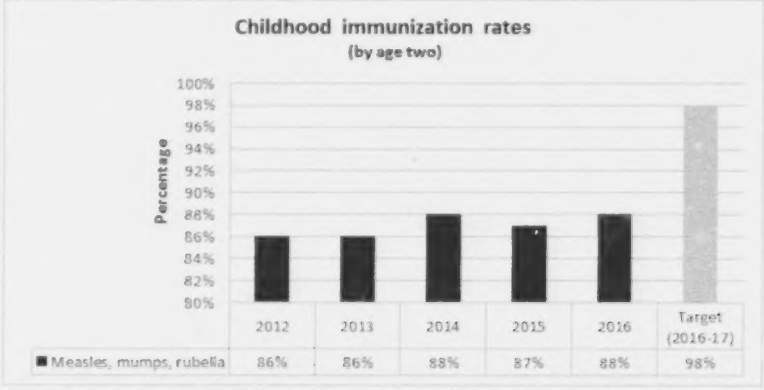
Results Analysis

There was a one per cent increase in the rate of immunization to prevent both measles, mumps and rubella (MMR) and diphtheria, tetanus, pertussis, polio and haemophilus influenza type b (DTaP-IPV- Hib) in 2016-17.

Targets are not easily achievable as vaccine hesitancy is increasing. Alberta has communities with a high number of non-immunizers, therefore immunization rates remain significantly below targets in those areas despite increasing access to vaccines and providing education about the benefits of immunization. Although national targets are not being met, immunization rates are staying relatively steady with small improvements year-over-year.



Source: Alberta Health Insurance Plan (AHCIP) Quarterly Population Registries, Immunization/Adverse Reactions to Immunization (Imm/ARI), Alberta Vital Statistics Birth Files.



Source: Alberta Health Insurance Plan (AHCIP) Quarterly Population Registries, Immunization/Adverse Reactions to Immunization (Imm/ARI), Alberta Vital Statistics Birth Files

The Department of Health and Alberta Health Services (AHS) continue working together on increasing coverage rates. For example, AHS will focus on increasing access and decreasing wait times at public health clinics for routine childhood immunization. Through amendments to the *Public Health Act*, there are enhancements to the school immunization program to better identify under-immunized students in all grades, supporting additional contacts for parents by public health professionals to facilitate and encourage updated immunization.

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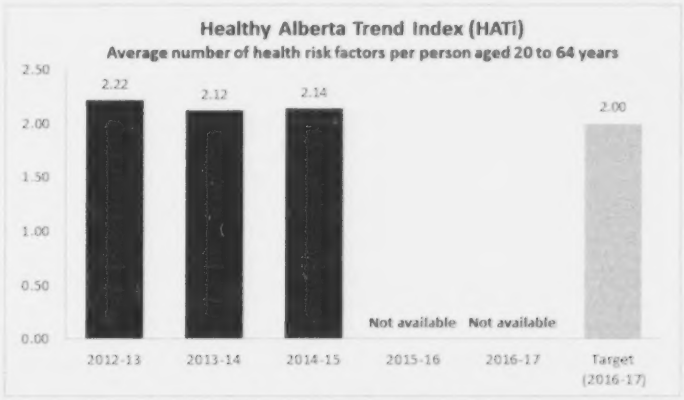
Performance Measure 2.c **Healthy Alberta Trend Index (HATi): Average number of health risk factors per person aged 20 to 64 years**

The Healthy Alberta Trend Index (HATi) is a composite index that measures six self-reported, complex health behaviours: life stress; BMI (overweight/obesity); fruit and vegetable consumption; physical activity; smoking status; and binge drinking alcohol.

Note: The 2015 results were not available in time for inclusion in the Annual Report. Statistics Canada re-vamped the Canadian Community Health Survey in 2015, which resulted in a substantial delay in release of the data compared to other years. The Department of Health has received the 2015 data, and is currently working with Statistics Canada to resolve some data quality issues. Results for 2016 were also not available at the time of publication.

Results Analysis

As the index measures population level shifts, the changes over time are notably small, incremental and often fluctuating. Shifts in the trends are driven by a range of factors, including socio-economic conditions. As such, targeted policy and program initiatives available within the health system are unlikely to have sufficient scope and reach to have a significant impact on the whole population. Results for 2014-15 were compared to results for 2013-14 due to the lack of data available for 2015-16 and 2016-17.



Source: Canadian Community Health Survey (CCHS), Statistics Canada.
Note: 2015-16 and 2016-17 results were not available at the time of this publication.

Given the number of interconnected determinants impacted by policy and program initiatives outside of the health system (such as housing, education, availability of childcare, etc.), the target of 2.0 was identified as potentially achievable over the next few years.

The government has implemented several initiatives to influence the HATi trend, such as:

- preventing and reducing tobacco use, including menthol and flavoured tobacco;
- offering resources and support to encourage healthy eating and active living for children; and,
- helping young adults learn about what it means to drink responsibly.

To understand the variation and fluctuations in the HATi, it is helpful to look at the six indicators that make up the index. Generally speaking, health risk behaviours are higher among men than women across all indicators, with the exception of physical activity. The following general trends have been observed over the last 10-year period:

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Consumption of Fruit and Vegetables: Females have consistently fared better on this indicator than males. From 2013 to 2014, the percentage of Albertans reporting they were eating more than five daily servings of fruit and vegetables decreased by 3.7 per cent. Potential factors impacting this shift include: a 2.6 per cent increase in the cost of food in Alberta over the period; and, in 2013, the Department of Health discontinued its Healthy U 5&1 social marketing campaign, which encouraged young Albertans and their parents to eat five helpings of fruit and vegetables and get one hour of physical activity per day.

Physical Activity: The results for this indicator have been very consistent over time with very little difference between the proportion of males and females that report engaging in regular physical activity. In 2014, 57 per cent of Albertans reported being active or moderately active.

Daily Smoking: This indicator has been consistently and significantly decreasing over time. The decrease has been driven primarily by the decline in the number of female daily smokers, although in 2014 the number of male daily smokers dropped to 16.5 per cent from 20.8 per cent in 2012.

Life stress: More males consistently report self-perceived stress levels as "extremely" or "quite a bit stressful" than females, but the differences are relatively small. This measure has been very stable over time.

Overweight/Obesity (BMI Category): Although the results have been relatively stable for this indicator for both males and females, there has been a slight overall increase since 2003 and a steady increase every year since 2010. The proportion of males being overweight has also been consistently and significantly higher than for females.

Binge Drinking Alcohol: Binge drinking is defined as males having five or more drinks or females having four or more drinks, two or more times per month. Almost twice as many males report binge drinking compared to females; however, the relative proportion of binge drinking among both sexes has remained relatively constant over time. In 2014, the percentage of Albertans reporting binge drinking decreased to 11.7 per cent from 14 per cent in 2013. This reduction is due to a decrease in binge drinking in males by almost six per cent from 2013 to 2014. Binge drinking among females increased slightly over the same time period.

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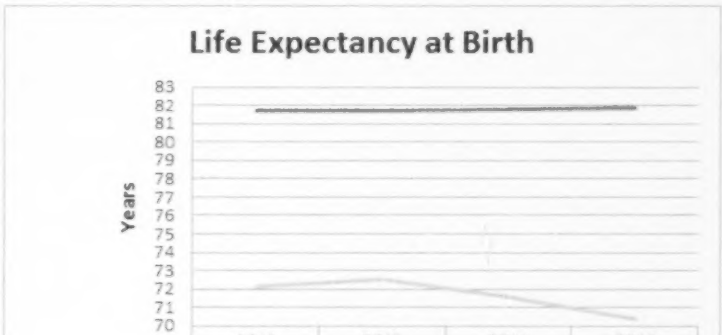
Performance Indicator 2.a **Life expectancy at birth (years):**

- **Provincial**
- **First Nations**

Life expectancy at birth provides the number of years a given birth cohort would be expected to live if current age and sex mortality rates remained in place. This measure compares the life expectancy of First Nations people to that of the total provincial population (which includes both First Nations and non-First Nations people). Note: The 2016 results were not available at the time of publication.

Results Analysis

Life expectancy is one of the most widely used measures of health status, and is an indicator of the overall health status of a population. Over the past nearly three decades in Alberta, life expectancy for the total provincial population has increased by five years, from 76.8 in 1986 to 81.8 in 2014.



	2012	2013	2014	2015
Provincial	81.68	81.71	81.79	81.87
First Nations	72.15	72.52	71.6	70.38

Source: Alberta Health Care Insurance Plan; Quarterly Population Registry Files; Alberta Health Postal Code Translation File; Alberta Vital Statistics Death File.
Note: 2016 results for this indicator were not available at the time of this publication.

Since it is a summary measure of mortality, it is affected by incidence of disease and injury, as well as survival (how long people live with a disease). Premature mortality would have a significant effect on life expectancy, and since a significant number of deaths are avoidable with prevention and effective health care, it follows that prevention and effective health care could have some impact on increasing life expectancy.

Life expectancy is affected by many factors including socio-economic status (employment, income, education, and economic wellbeing); health system quality (i.e., access); health behaviors (tobacco and alcohol consumption, diet, physical activity); and, social, genetic and environmental factors.

There is a significant difference in life expectancy for Alberta's First Nations population as compared to Alberta's total provincial population (which includes First Nations). In comparison to Alberta's total population, the First Nations population experiences higher infant mortality and suicide rates, a higher rate of diabetes, and significantly higher rates of arthritis, asthma, heart disease, and high blood pressure. First Nations people also experience greater challenges related to the social determinants of health, such as safe and secure housing, employment, education and food security. This has a tremendous impact on life expectancy. This is consistent with national results which indicate the health of Indigenous peoples is much worse than for Canadians as a whole. To improve the health status of a population, a broad range of factors need to be considered including health services, personal health practices and coping skills, and social factors such as housing and education.

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Performance Indicator 2.b **Infant mortality rate (per 1,000 live births)**

- **Provincial**
- **First Nations**

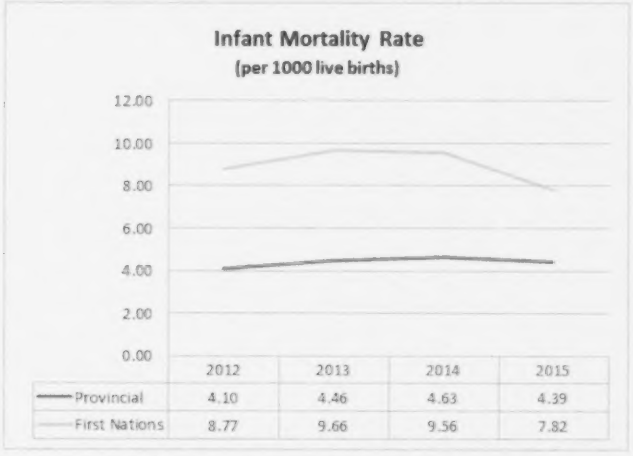
The infant mortality rate provides the number of infants aged less than one year that die, per 1,000 live births. Like life expectancy, infant mortality rate is an indicator of the overall health status of a population. Note: The 2016 results were not available at the time of publication.

Results Analysis

The infant mortality rate is often used as an indicator to measure the health status of a general population, because factors affecting the health of entire populations can also impact the mortality rate of infants.

There is a significant difference in the rate for Alberta's First Nations population in comparison to Alberta's total provincial population. Compared to Alberta's total population, the First Nations population experiences a higher number of preterm births, which is the main cause of infant mortality. The other most common causes of infant death are birth defects, maternal complications during pregnancy, sudden infant death syndrome, and injuries (such as suffocation).

Risk factors include mother's age, level of education, income, access to health services, and personal health behaviors (i.e., smoking, alcohol and drug use, nutrition, use of folic acid, and physical activity).



	2012	2013	2014	2015
Provincial	4.10	4.46	4.63	4.39
First Nations	8.77	9.66	9.56	7.82

Source: Alberta Vital Statistics Death File (infant deaths); Newborn Metabolic Screening Database (live births); First Nations Status Registry.
Note: 2016 results for this indicator were not available at the time of this publication.

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DESIRED OUTCOME THREE: Albertans receive care from highly skilled health care providers and teams, working to their full scope of practice

Achievements

(3.1) Improve access to health care providers across the province and develop sustainable strategies that ensure the appropriate education, scope of practice, supply and distribution of health care providers

In September 2016, the *Paramedics Profession Regulation* under the *Health Professions Act* came into effect. As a result, paramedics have increased self-governance on par with other health professions in Alberta. The new regulation supports increased use of paramedics in rural settings, long-term care facilities, and health care clinics in industrial worksite settings including:

- expanding the role and services of paramedics to improve the ability of rural and remote clinics to provide more effective primary care services;
- adapting medical oversight to enable collaboration between paramedics and nurse practitioners to provide innovative care in patients' homes;
- implementing practice innovations such as portable lab analysis to allow paramedics to safely care for patients in their homes and reduce the number of patients transported to hospital; and,
- authorizing Emergency Medical Technicians to administer naloxone and paramedics to dispense naloxone for fentanyl overdoses.

On February 7, 2017, the Government of Alberta announced several new initiatives to increase access to naloxone, such as permitting firefighters, police officers and peace officers to administer injectable naloxone. Employers of these first responders are free to make their own operational decisions about their employees carrying and administering naloxone. Naloxone can be accessed through the Alberta Health Services (AHS) Take Home Naloxone program. Training is required prior to these first responders being able to administer naloxone.

As part of Budget 2016, the Government of Alberta allocated an additional $11 million for midwifery services over the next three years making it a more accessible option for Albertans. This funding is in addition to the $38 million already budgeted for midwifery services during this period, and the $1.8 million AHS pays annually to subsidize midwives' liability insurance. This allocation helped serve an additional 391 women in 2016-17. Together with AHS and the Alberta Association of Midwives, the department is working to align midwifery services with the needs and priorities of maternity health service delivery. AHS is targeting growth of midwifery services to geographic areas of need and populations that would most benefit from the services.

In February 2017, the ministry launched the Nurse Practitioner (NP) Demonstration Project, a three-year, $10 million, initiative which supports the integration and increased use of NPs and other providers in the community, particularly in areas that serve vulnerable, high-need populations. The Institute of Health Economics has been engaged to complete an objective, third-party evaluation of the NP Demonstration Project over the three-year period. The department also engaged experts in the field of nursing research across Canada to participate in an expert advisory group to provide expertise and guidance to ensure the successful design, implementation and evaluation of the NP Demonstration Project.

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(3.2) Enhance accountability and promote practice excellence among regulated health care providers.

In May 2016, the *Health Professions Act* was amended to provide regulation of physician assistants within the College of Physicians & Surgeons of Alberta and diagnostic medical sonographers within the Alberta College of Medical Diagnostic and Therapeutic Technologists. These changes will take effect when appropriate regulations have been developed by the colleges. Currently, physician assistants and diagnostic medical sonographers provide their services under the authority of the physicians who supervise them. Once regulations are approved, they will become regulated health professionals and subject to the Act and the Standards of Practice and Codes of Ethics of their respective colleges. The amendments to the Act also updated descriptions of services provided by several professions, including midwives, paramedics and chiropractors.

Throughout the year, the department reviewed and provided feedback on several proposals by councils for colleges to adopt new or amended standards of practice or codes of ethics for their members. These include code of ethics or standards of practice from the College of Physicians & Surgeons of Alberta, Physiotherapy Alberta College + Association, and the Alberta College of Pharmacists.

In May 2016, the Department of Health, in collaboration with the College of Naturopathic Doctors of Alberta (CNDA), initiated a review of the CNDA's code of ethics and standards of practice. The purpose of the review is to create public confidence, set minimum standards and provide direction to naturopathic doctors in the provision of naturopathic services, and protect the public through promotion of practice excellence in the provision of naturopathic services.

In 2016-17, the department completed a review of factors influencing Alberta dental service fees in both public and private markets, including making dental fee comparisons to other provinces, and determining whether the dual roles of the Alberta Dental Association + College (ADA+C) influence dental fees. The results of the review were released publicly in December 2016 (www.health.alberta.ca/documents/Dental-Fee-Review-2016.pdf) and include the perspectives of national and provincial stakeholders. The review's findings provide Albertans with information to enable them to be more informed consumers of dental services and dental plans. In addition, this review highlighted areas for continual evaluation with the ADA+C. Further work to support a dental fee guide is underway.

(3.3) Develop sustainable physician compensation models which enable the provision of high quality care and support collaborative practice within a team-based environment

The Department of Health developed a new compensation model for primary care physicians in 2016-17, called the Blended Capitation Model, where compensation is derived primarily from fixed annual payments based on the characteristics of the patients under their care (capitation) rather than the number of medical services provided to their patients (fee-for-service). The Blended Capitation Model is intended to achieve greater budget predictability of primary health care expenditures, establishment of a patient-centered medical home, improved patient access to primary health care, and encourage and expand the use of multi-disciplinary teams in the delivery of primary health care.

The model was developed in collaboration with the Alberta Medical Association and AHS and its implementation will begin as a 36-month demonstration project. During this period, the viability of the model will be explored across an initial wave of five demonstration clinics.

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(3.4) Increase timely access for all Albertans to primary health care services where they see the right provider at the right time

Access to health care services can be limited by geography, hours of operation, and wait times. The Department of Health, with the support of Primary Care Network (PCN) leadership, set out revised PCN objectives to more clearly address Albertans' need to have timely access to interdisciplinary, team-based primary health care. Under policy changes made during 2016-17, PCNs will retain only a small portion of any surpluses they might accumulate each year so they can continue to direct funding to patient care.

Primary health care team members, including physicians, receive support through AHS, PCNs and department-funded quality improvement programs. These programs are expected to improve processes and address capacity issues, and ultimately lead to improved access for Albertans.

PCNs are required to report to the department on the percentage of physicians using a standard access measure to track wait times. For 2015-16, PCNs reported that 41 per cent of member physicians were using a standard access measure to track wait times for patient visits. Over time, physicians are expected to use the results of this ongoing measurement to identify and address wait time concerns.

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Performance Measures and Indicators

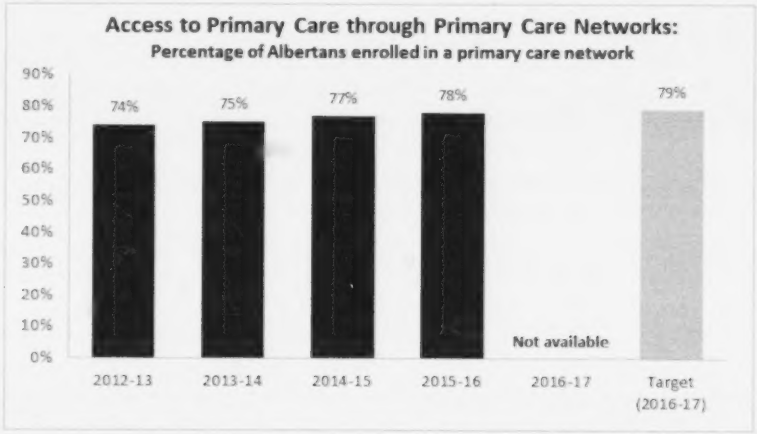
Performance Measure 3.a **Access to primary care through primary care networks: Percentage of Albertans enrolled in a primary care network**

This measure is defined as the percentage of Albertans informally enrolled in a Primary Care Network (PCN) as of March 31 of a given year. The result of this measure is based on the total number of patients enrolled in a PCN as a proportion of the total population covered under the Alberta Health Care Insurance Plan in a given fiscal year.

Note: The 2016-17 result for this performance measure was not available at the time of publication.

Results Analysis

For 2015-16, the result of this measure shows that 78 per cent of Albertans have access to primary care through a PCN. This result is one per cent higher than the previous year's results and may be due to an increase of 272 physicians participating in PCNs in 2015-16, bringing the total number of physicians participating in PCNs in 2015-16 to 3,836. The trend demonstrates a gradual increase over time in both the number of physicians and Albertans associated with PCNs.



Source: Ministry of Health, Alberta Health Care Insurance Plan Statistical Supplement, 2015-16; Claims Assessment System (CLASS).
Note: 2016-17 results were not available at the time of this publication.

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DESIRED OUTCOME FOUR: A high quality, stable, accountable and sustainable health system

Achievements

(4.1) Support the creation of a stable budget for health care services to help Albertans receive the right care, at the right time, from the right provider, and in the right place

The Government of Alberta maintained stable funding for health care while upholding a slower, more sustainable spending rate than the historical average spending increases of six per cent. The consolidated operating spending increase between 2015-16 and 2016-17 was 3.1 per cent.

Physician compensation is a significant component of health care spending in Alberta. Negotiations between the Department of Health, Alberta Health Services (AHS), and the Alberta Medical Association resulted in an agreement that recognizes a shared responsibility to provide quality health care in a financially sustainable framework. The amending agreement was signed on November 18, 2016, and represents a significant step toward slowing the growth of health spending while protecting health services.

Financial sustainability is also about identifying opportunities to deliver health services and operate more efficiently. AHS uses operational best practice, which involves comparing AHS health care service delivery with counterparts in other jurisdictions, to guide planning and implement leading practices and process improvements. These types of initiatives are underway, designed to achieve clinical and operational efficiencies and cost savings while continuing to maintain or improve the quality and safety of care for patients.

Alberta continued to be an active participant in the pan-Canadian Pharmaceutical Alliance (PCPA), a group representing all 13 provinces and territories and the federal drug plans. The PCPA is leveraging its combined purchasing power to achieve better value for drugs and to ensure more consistent drug funding decisions. As of May 31, 2017, 153 joint negotiations resulting in agreements have been reached and significant price reductions on 18 of the highest volume generic drugs have been secured. Work continues to renew the pricing frameworks and continue negotiations on new products coming to market.

The Department of Health also implemented a number of measures to support the evidence-informed and effective use of prescription drugs on government drug plans. This included changes to the coverage of some medication groups such as, for example, the maximum allowable cost program for Proton Pump Inhibitors (PPI), a medication used to manage stomach acid. Starting in February 2017, coverage for PPIs was provided only for the lowest cost medications. This change is expected to reduce costs to both the patient and the province and result in the same health outcomes as using more expensive drugs.

Canada's provinces and territories, with the exception of Quebec, participate in reciprocal medical agreements. This means residents receive insured health services outside of their province/territory of residence, the cost of which are then billed back to the resident's home province/territory.

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In 2016-17, advocacy by Alberta resulted in the approval by the Interprovincial Health Insurance Agreement Coordinating Committee of 13 new high-cost procedures and special implants/devices to be added to the billing fees list to improve Alberta's hospitals ability to recover costs. Over the next two years, the Department of Health will lead a pan-Canadian policy research group with the aim of increasing consistency and co-ordination of interprovincial billing practices.

(4.2) Ensure regional health care needs are heard and addressed

The Government of Alberta is committed to meeting the health care needs of all Albertans, both urban and rural, and envisions a health care system that is structured and planned around individuals and their communities. The Department of Health and AHS worked with local health providers, community leaders and citizens to improve access to urgent health care in Airdrie and Sylvan Lake. In Airdrie, the urgent care centre was expanded to 24 hours per day beginning in spring 2017. As a result of efforts by the department, AHS and the Sylvan Lake joint task force, renovations to the Sylvan Lake Community Health Centre were also initiated to support new treatment spaces, an expanded waiting area, installation of a nurse call system, as well as improvements to laboratory services and diagnostic imaging. The work is expected to be completed by 2018 to begin care for non-life-threatening injuries up to 16 hours a day, seven days a week.

The department also continued to support and participate in AHS' Zone Long Range Planning to ensure the voice of patients, community members and providers is taken into account. AHS intends to provide long-range plans to 2031 for zones to shape care based on current and future needs of Albertans. Work this year focused primarily on AHS' Central and Calgary Zones. This activity closely aligns with the vision of enhancing care in the community.

(4.3) Repair aging health infrastructure and build new health care facilities, where appropriate, to ensure that such infrastructure meets current and future health care needs

The Government of Alberta is committed to strengthening health infrastructure to protect and improve health care services for Albertans. In 2016-17, a total of $251.9 million was spent to continue 27 approved health facilities projects, and programs to repair aging infrastructure and/or build new health infrastructure.

Several health infrastructure projects were completed during 2016-17, including:

- the new Edson Health Care Centre, which replaces the old hospital facility;
- the new High Prairie Health Complex, which replaces the old hospital facility;
- a new CASA facility in Edmonton, replacing the original facility and providing specialized mental health services for children, adolescents and their families from Edmonton and central and northern Alberta;
- renovations for a new Concurrent Disorder Capable Treatment Continuum program at the Royal Alexandra Hospital in Edmonton, which provides additional addictions and mental health treatment capacity; and,
- a new addition to the Medicine Hat Regional Hospital, which upgrades and/or expands many important clinical services from the old Medicine Hat Regional Hospital.

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In addition to the above, the Government of Alberta provides annual funding to AHS through the Infrastructure Maintenance Program to maintain health facilities across the province. In 2016-17, $145.7 million was spent to preserve and maintain health facilities throughout Alberta to support the delivery of publically funded health programs and services. A further $25 million was provided for the Medical Equipment Replacement and Upgrade Program.

(4.4) Enhance accountability through improved governance structures and establish clear mandates and roles for all health agencies, boards and commissions

The *Alberta Public Agencies Governance Act* requires agencies to have a mandate and roles document, codes of conduct, and a competency-based recruitment process. These documents and processes must be made publicly available. The ministry continued working to ensure its agencies which are governed by the Act meet these requirements. During 2016-17, the mandate and roles documents for the Hospital Privileges Appeal Board, the Health Disciplines Board and AHS were signed.

More than 70 members were appointed to Alberta Health's public agencies during 2016-17, including the Health Quality Council of Alberta (HQCA), Public Health Appeal Board, the College of Licensed Practical Nurses of Alberta, and the College of Hearing Aid Practitioners. This supports the successful roll-out of the new government-wide recruitment and appointment process. From September 2016 to March 2017, the department publicly advertised on www.boards.alberta.ca for 165 member positions on 10 public entities. In addition, the three Mental Health Review Panels were amalgamated to create the Mental Health Review Panel Roster to help ensure ease in administration and more effective governance.

The *Reform of Agencies, Boards and Commissions Compensation Act* and related regulation brought compensation provided to the CEO of the HQCA in line with compensation provided to those in comparable positions in other public sector organizations across Canada. Public disclosure of remuneration paid in 2015 to all of the ministry's public agency board members and salaries paid to staff of public agencies, including AHS and the HQCA, was posted publicly on the department, AHS and HQCA websites.

(4.5) Implement a system-wide response to chronic conditions and disease prevention and management by aligning and integrating current work being done on chronic disease across the province

The Department of Health has been working with AHS and key community stakeholders on the development of the Chronic Condition and Disease Prevention and Management (CCDPM) Initiative. The objectives of this initiative are to develop a common understanding of the current state of CCDPM in Alberta, align Alberta's efforts on CCDPM across government and non-government partners, develop a CCDPM Framework in collaboration with AHS, and establish a reporting mechanism.

This work was undertaken in response to the growing number of Albertans living with chronic conditions and diseases, the fragmented approach to supports and services across the health care system, and gaps between the health care system and community supports. Consultation with AHS is ongoing and in August 2016 agreement was reached on the shared CCDPM definitions, vision, and eight goal statements.

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These elements are the foundation of the CCDPM Framework, and are intended to align diverse stakeholders to move from disease-specific to whole person-centered service delivery. The framework is expected to create opportunities for stakeholders to support and contribute to improving the health and quality of life for Albertans by improving their ability to self-manage and be partners in their own care, as well as increase the efficiency of the health and social systems.

The January 2017 CCDPM Forum provided the first opportunity to share the vision of an integrated approach to CCPDM with extended internal and external stakeholders. Feedback from the CCPDM Forum is being used to guide and plan next steps in the framework's development, including creating platforms for diverse stakeholders to connect, the creation of indicators, and establishment of a reporting mechanism.

(4.6) Increase the capacity for evidence-informed practice and policy through clinical information systems, enhanced data sharing, research, innovation, health technology assessment and knowledge translation

The Department of Health has a number of ongoing initiatives that increase provincial capacity for evidence-informed decision making. Health Technology Assessments provide comprehensive and contextualized evidence to support optimal and innovative health care delivery. In 2016-17, the department completed 12 assessments and reviews on a range of topics, including glucose monitoring technologies, community paramedicine, assisted reproductive technologies, insulin pump therapy, and hysteroscopic tubal sterilization. In addition, an exploratory brief identifying commercially available or emerging glucose monitoring technologies in North America is being used by the ministry in its price negotiations to obtain blood glucose testing supplies at a lower cost for Albertans.

The Legalization of Cannabis Evidence Series, a report authored by the Health Technology Assessment Unit at the University of Calgary through support from the department, explored potential health risks and harms, public opinion, the experiences of other jurisdictions, and the policy implications of legalizing cannabis. A cross-ministerial committee is using these findings to inform provincial policy positions, legislation, and regulations, and prioritize areas for policy work.

Knowledge Translation enables the use of evidence to inform decision making at all levels. In 2016-17, based on the Legalization of Cannabis Evidence Series and in partnership with the Canadian Agency for Drugs and Technologies, the department developed a Cannabis Knowledge Translation Tool for Physicians. The tool supplies physicians with an easy reference guide that summarizes the evidence related to efficacy and safety that physicians need in order to prescribe cannabis for medical use or to discuss cannabis use with patients.

In 2016-17, the Department of Health provided $11.4 million in financial support through the Alberta Cancer Prevention Legacy Fund toward: Alberta's Tomorrow Project, to support a research study that examines why some people get cancer while others don't; Alberta Innovates, to support existing cancer research commitments; and, other cancer research initiatives.

The procurement process for an AHS Clinical Information System (CIS) was initiated during 2016-17. The system is intended to replace aging and obsolete information technology platforms across all AHS Zones.

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The Health Information and Data Governance Committee, established in September 2016, provides governance for health information in provincial systems and secondary use information to better serve patients and Albertans. The committee is providing oversight to the development of a new Information Sharing Construct to support the AHS CIS.

In February 2017, the department co-hosted an eHealth symposium with the O'Brien Institute for Public Health and the Institute of Health Economics to discuss the concept of integrated health records and appropriate sharing of health information between health care professionals.

(4.7) Enable a more robust health system analytics environment in which to better inform quality improvements, health system management, delivery and research

The Department of Health, working with Alberta universities, continued to provide the ministry with fundamental data to protect the health of Albertans from contaminants that may be present in the environment and that may enter their air, food or drinking water sources, and/or in river or lakes systems that they may swim in, boat on or use for recreation.

The Alberta Centre for Toxicology provides testing for Albertans in AHS' Opioid Dependency Program to evaluate an individual's pattern of drug use and determine if they are taking their prescribed treatment. In 2016-17, 9,724 samples were submitted for testing, a 57 per cent increase since 2015-16. The department also continued working with the Office of the Chief Medical Examiner (OCME) and AHS to enhance opioid surveillance. The collaborative work with the OCME is being extended to address other health issues (e.g., suicide, injuries).

The Provincial Health Information Strategy, currently under development, will leverage the existing assets of Alberta Netcare, the Personal Health Record, community-based systems and, in time, the AHS CIS, to develop a more robust health information environment that is centered on the individual, enables better care delivery and supports health system planning, management, quality assurance, monitoring and research. Alongside the strategy, the department collaborated with AHS on a system that will help manage the risk of data disclosure, as well as the ability to create anonymized, highly de-identified data to support testing, large volume disclosure, and the creation of data to support secondary use.

The department also had a leadership role with the Secondary Use Data Project to improve researcher access to data, and continued contributions and support to the Government of Alberta (GoA) OpenData program. The ministry maintains 303 health system-related catalogue entries in the GoA OpenData Portal.

In 2016-17, the department continued the development, operation and management of the Data Warehouse and Business Intelligence Environment, as well as the development and implementation of health information standards.

An overarching draft of a data sharing Privacy Impact Assessment was completed in January 2017 to facilitate more efficient and timely sharing of health system data between the department and AHS.

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(4.8) Improve performance of emergency departments for enhanced patient flow through the acute care system

Improving patient flow in emergency departments is complex and requires many co-ordinated actions, such as improving access to primary care and enhancing the continuity of care for patients who are discharged from inpatient hospital beds to appropriate community-based care settings.

Despite challenges of increasing occupancy and demand, and the percentage of patients requiring alternate levels of care, emergency department flow improved overall during 2016-17. Half of all patients in emergency departments were treated and admitted within the target eight hours, a measure that remained stable in the third quarter of 2016-17 compared to the same time last year. Alberta also saw an improvement in the actual length of acute stay compared to expected length of stay in 2016-17. This improvement is a trend that has continued in the province for the last five years.

The department is working with AHS on co-ordinated patient flow strategies focusing on timely inpatient discharges and enabling emergency department efficiency. The second phase of CoACT implementation began in March 2017 in all AHS zones and three Covenant Health facilities. CoACT is an innovative model of care in which care provider teams collaborate more closely with patients and will help to improve co-ordination and communication between care providers and physicians, ensuring patient-centred, collaborative care and smooth transitions for patients moving between levels of care. In support of this, AHS has begun a bed movement process to move patients to vacant beds in a timelier fashion.

The Emergency Strategic Clinic Network (SCN) also continues to support quality patient- and family-centred emergency care driven by education, innovation and practice-changing research through collaboration. In February 2017, the Emergency SCN announced a grant-funded initiative that focuses on building better transitions for patients in care involving an emergency department.

The HQCA launched its FOCUS on Emergency Departments website, which presents 18 measures in the form of interactive charts and allows Albertans, emergency department professionals, healthcare administrators, and patients to look at the measures and understand what is happening at the province's 16 largest/busiest Emergency Department (ED) sites. Every two weeks, the HQCA surveys a sample of ED patients and publishes the results as part of the FOCUS website. As of March 2017, nearly 16,000 Albertans were surveyed regarding their experience within the ED.

The ministry is working to establish urgent care centres and increase the availability of after-hours primary care through Primary Care Networks to facilitate the discharge of patients from hospitals. These initiatives will help free up space in emergency departments for urgent cases.

The Government of Alberta remains committed to an increase of 2,000 long-term care and dementia care beds across Alberta by 2019. The addition of new long-term care and dementia care beds frees up emergency department and hospital beds, improves access to acute care services, and allows more Albertans to receive care closer to home. As part of this commitment, construction of new long-term care and dementia care beds has begun in Calgary and Edmonton, as well as in other communities. In addition, AHS continues to implement the Designated Living Option: Access and Waitlist Management in Continuing Care policy which requires that each client and their family receives sufficient information, support, and time to decide on one or more living options that will be suitable to meet the client's needs and preferences as they move into care from either acute care or their home.

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Performance Measures and Indicators

Performance Measure 4.a **Satisfaction with health care services received: Percentage of Albertans satisfied or very satisfied with health care services personally received in Alberta within the past year**

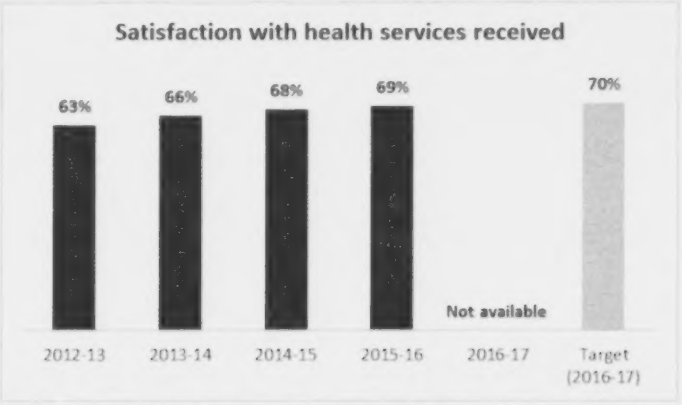
Patient satisfaction with health care services is a crucial and critical dimension of quality. It is an indicator of the structure, process and outcomes of care in Alberta's health care system, and helps assess performance of the health system in delivering high quality, patient-centred care.

Note: Results for 2016 are not available. Responses to this telephone survey, conducted by the Health Quality Council of Alberta, have decreased significantly over time and therefore the survey has been discontinued.

Results Analysis

A survey of Albertans was not conducted in 2016-17. Based on the 2015-16 survey, 69 per cent of Albertans surveyed were satisfied or very satisfied with health care services received, which is not statistically different from the 2014-15 or 2013-14 results.

In addition to personal experiences with the health care system, satisfaction with health care services may be influenced by recent news reports, current events, changes to local health system infrastructure, and perceptions of policy or system changes.



Source: HQCA. Satisfaction and Experience with Health Care Services: A Survey of Albertans 2010, 2012, 2014, 2016). HQCA. Provincial Survey About Health and the Health System in Alberta (2011, 2013). Note: A survey of Albertans was not conducted in 2016-17; the survey has been discontinued.

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Performance Indicator 4.a **Patient safety: Percentage of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year**

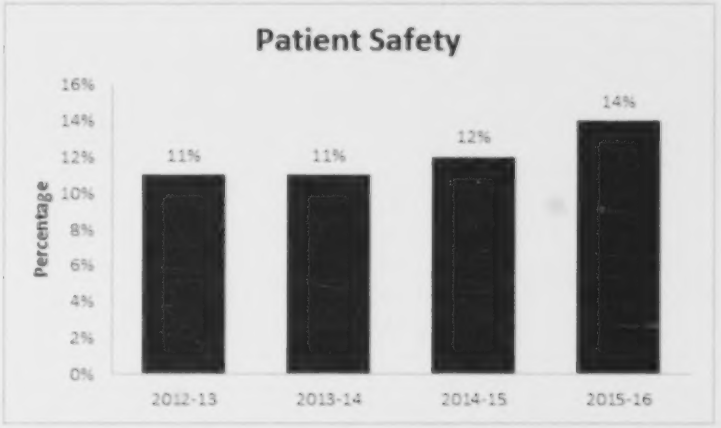
Patient experience with adverse events is a high level indicator of system safety. Sometimes when people receive health care, unexpected harm can occur as a result of that care. Such unexpected harm is different from complications which may occur as an expected risk of some treatments.

Unexpected harm can affect a patient's health and/or quality of life and can result in additional or prolonged treatment, pain or suffering, disability or death. Monitoring patient experience supports the provision of safe care to improve patient outcomes and fosters continuous improvement in patient safety in Alberta.

Note: Results for 2016 are not available. Responses to this telephone survey, conducted by the Health Quality Council of Alberta, have decreased significantly over time and therefore the survey has been discontinued.

Results Analysis

A survey of Albertans was not conducted in 2016-17. Based on the 2015-16 survey, the results for the last five years show the experience reported by survey participants as stable for three years but increasing over the past two years. Results are reliable within 1.9 per cent, 19 times out of 20.



Source: HQCA. Provincial Survey about Health and the Health System in Alberta (2013, 2015, 2016). HQCA. Satisfaction and Experience with Health Care Services in Alberta (2012, 2014).
Note: The survey has been discontinued in 2016.

There was no statistically significant difference in the per cent of Albertans who reported they, or a family member experienced unexpected harm while receiving health care in Alberta, in 2016, compared to 2006, 2009, 2011, and 2015. There was a statistically significant difference in 2016 compared to 2008, 2010, 2012, 2013, and 2014.

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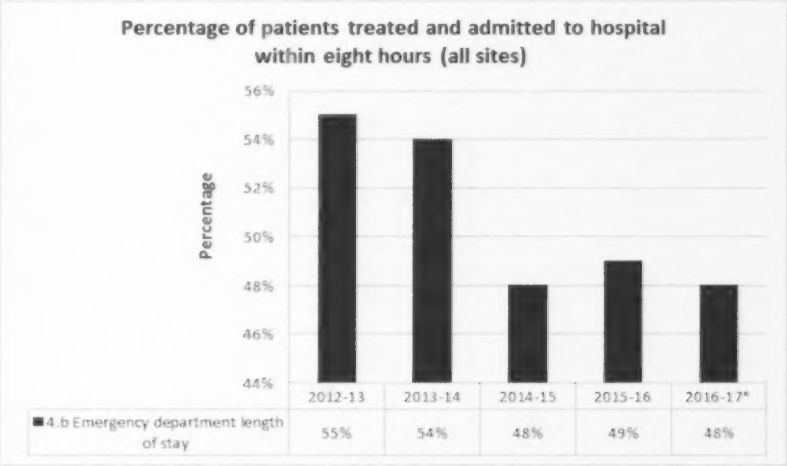
Performance Indicator 4.b **Emergency department length of stay: Percentage of patients treated and admitted to hospital within eight hours (all sites)**

Patients treated in an emergency department or urgent care centre should be assessed and treated in a timely fashion to ensure quality of care. This indicator tracks length of stay in emergency departments that are located in facilities with inpatient spaces. The emergency department length of stay for admitted patients is measured from the earliest reported time after arrival in the emergency department (either the triage or registration time) to the time the patient enters the hospital as an inpatient following discharge from the emergency department.

Results Analysis

For 2016-17, the percentage of patients treated and admitted to hospital within eight hours (all sites) dropped from 49 per cent to 48 per cent. Progress has been made since 2012-13, although the last three years are at about the same level.



Source: National Ambulatory Care Reporting System format (NACRS) NACRS sites: All Alberta hospital sites.
* Note: 2016-17 results (48%) are preliminary results.

Alberta emergency rooms are operated by Alberta Health Services (AHS) which is taking action to reduce wait times throughout the health system. AHS has set targets for improvement in accessibility for emergency department services by also tracking the emergency department length of stay for admitted patients. The AHS measure is the average length of stay for 2016-17 was 9.3 hours. Further information is available at: www.albertahealthservices.ca/about/performance.aspx.

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Performance Indicator 4.c **Albertans rating of the quality of health care services received (biennial survey)**

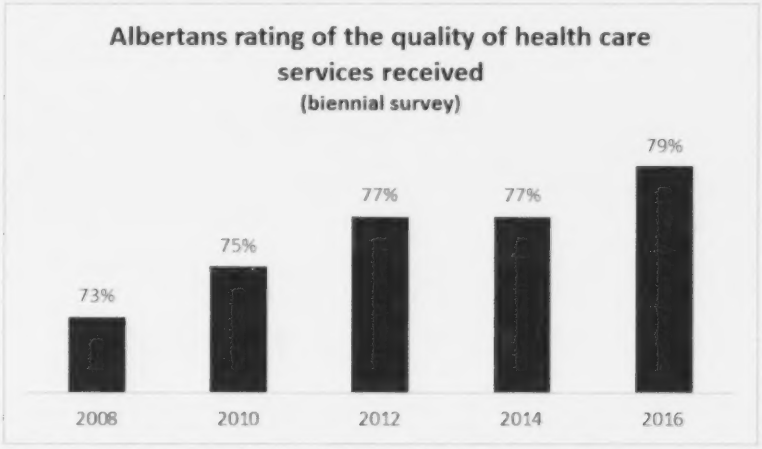
This indicator examines Albertans' perceptions of the overall quality of health care services received within the past year. Services include those that may be provided by family physicians, specialist physicians, pharmacists, mental health therapists, or other healthcare professionals. This rating is an indicator of whether Alberta's health care system is safe, effective, patient-centred, timely, efficient, and equitable in meeting the needs of Albertans.

Results Analysis

This survey is conducted biennially. The last survey was conducted in 2016, and the next survey is to be undertaken in 2018.

In 2016, 79 per cent of survey respondents described the quality of health care services received as good or excellent.

In addition to personal experiences with the health care system, perceptions of the overall quality of health care services received may be influenced by recent news reports, current events, changes to local health system infrastructure, and perceptions of policy or system changes.



Source: HQCA. Provincial Survey about Health and the Health System in Alberta (2011, 2013, 2015, 2016). HQCA. Satisfaction and Experience with Health Care Services in Alberta (2010. 2012, 2014).

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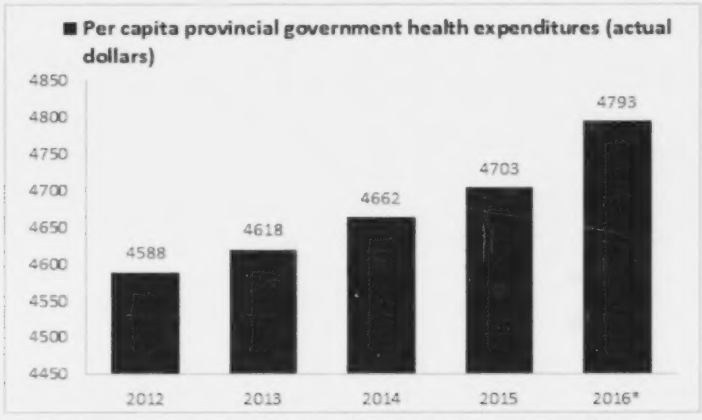
Performance Indicator 4.d **Per capita provincial government health expenditures (actual dollars)**

This indicator includes spending by the ministry, including Alberta Health Services (AHS), and health-related spending by other government departments and agencies and is a gauge of the overall success of cost containment initiatives. The goal is to slow the growth of overall government health spending to help make the system sustainable.

Results Analysis

The 20-year trend (1996-2016) in per capita cost showed an average increase of 6.1 per cent, per year. Recent cost containment efforts have resulted in a downward trend in per capita cost increases. The current forecast result for 2015 and 2016 shows smaller growth in per capita provincial government expenditures of 1.9 per cent between 2015 and 2016, which is below population growth and inflation combined.



Source: Canadian Institute of Health Information (CIHI), National Health Expenditure Trends (NHEX), 1975 to 2016.
* Note: 2016 result ($4,793) is forecasted. Forecasted results for the calendar year are available in November of the forecast year; actual results have a two-year lag.

The Department of Health continues to work in collaboration with key health system partners such as AHS and the Alberta Medical Association to ensure value for money. This involves improving health outcomes while bringing spending more in line with other provinces, particularly in the three high-cost areas of acute care (hospitals), physician compensation, and prescription drugs. Curbing spending in these areas is expected to free up health dollars to invest in the shift to more community-based care, including mental health and addiction services, primary care, home care, continuing care, and improving health outcomes for Indigenous Albertans.

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Results Analysis

Performance Measure and Indicator Methodology

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RESULTS ANALYSIS

Performance Measure and Indicator Methodology

Performance Measures indicate the degree of success a ministry has in achieving its desired outcomes. Performance measures contain targets which identify a desired level of performance to be achieved in each year of the business plan.

Performance Indicators assist in assessing performance where causal links are not necessarily obvious. The ministry may or may not have direct influence on a performance indicator; therefore, they do not contain targets.

Performance Measure 1.a	Access to continuing care: Percentage of clients placed in continuing care within 30 days of being assessed						
	RESULTS					**TARGET**	
	2012-13	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**2016-17**	
	67%	69%	60%	60%	**56%**	**62%**	

Source
Alberta Health Services: Data are extracted from 7 Meditech rings for the South, Central and North Zones and from 2 Strata Health Pathways applications by the Calgary and Edmonton Zones.

Methodology
Percentage of clients admitted to a Continuing Care Living Option (Designated Supportive Living or Long-term Care) within 30 days of the Assessed and Approved date.

Continuing Care Living Option refers to the level of care in a publicly funded resident accommodation that provides health and support services appropriate to meet the client's assessed unmet needs (i.e., Designated Supportive Living Level 3 or 4, 4-Dementia or Long-Term Care).

Assessed and Approved date refers to the date the client is placed on the waitlist for a Continuing Care Living Option following the completion of the assessment and approval process.

Calculation of Results: The number of individuals admitted to a Continuing Care Living Option within 30 days of their Assessed and Approved Date, divided by the total number of individuals admitted to a Continuing Care Living Option (Designated Supportive Living or Long-term Care) during the response period, multiplied by 100.

Note: The data excludes clients assessed and approved but not yet admitted during the reporting period; clients in the process of being approved for continuing care living options; clients admitted to another zone from the reporting zone to avoid double-counting; clients referred for home care services; clients admitted to a sub-acute unit or a rehabilitation unit; clients admitted to a hospice or palliative care unit; clients admitted to an acute care bed/service for another acute care bed/service (e.g., surgical bed to a medical bed); and clients transferred to a non-tertiary acute care hospital bed (e.g., repatriated to a community hospital).

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Performance Measure 1.b	Percentage of mental health patients with unplanned readmissions within 30 days of leaving hospital					
	RESULTS[1]					**TARGET**
	2012-13	**2013-14**	**2014-15**	**2015-16**	**2016-17**[2]	**2016-17**
	9.6%	8.9%	8.8%	8.6%	**8.6%**	**8.8%**

Notes:

1. Information is available once data from the Discharge Abstract Database (DAD) is collected by all facilities in the province and loaded into the provincial database. Enforced reporting lag is applied (90 days) to allow for completion of stay and load of the abstract record for the readmission stay.

2. Readmission rates are attributed to the quarter in which a patient is originally discharged from an acute care hospital. This requires that patients be tracked for 30 days after the end of the quarter to allow sufficient time from the date of initial discharge to determine whether a readmission will occur. Readmission rate reporting always lags by a quarter for this reason.

   Since transfer is excluded from readmission and there are several non-standardized ways to determine whether a transfer has occurred, the readmission rates published elsewhere could differ.

   Since there is not a standard method to identify unplanned readmissions (e.g., admissions through emergency ambulatory care), readmission rates published elsewhere may differ.

   Unplanned admission is defined as admit category = 'U' which is urgent/emergent admission. The data reliability is highly dependent on the accuracy of this field.

Source

Canadian Institute for Health Information (CIHI)
Alberta Health Services, Provincial Inpatient Database (DAD)

Methodology

The unit of analysis is an inpatient encounter within a single acute inpatient facility. Discharges to transfer between acute inpatient facilities are excluded although the discharge from the final facility after transfers would be included. In this way, episodes of care are identified with the reporting facility identified as the final discharging facility.

For consistency purposes, the annual target has been set to be the same as the target set by Alberta Health Services (AHS). All of AHS' publicly reported performance measures go through a rigorous target-setting rationalization process. This process includes final input by site and zone leadership and is aimed at increasing accountability at the site level. The process includes benchmarking against other sites, historical trending and relationships to volumes and service pressures, and acknowledges local variation and pressures.

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Performance Measure 1.c	Access to the provincial Electronic Health Record (EHR): Number of health care professionals with access to EHR					
	RESULTS					TARGET
	2012-13	2013-14	2014-15	2015-16	2016-17	2016-17
	N/A[1]	N/A[1]	37,324	40,587	**42,090**	**41,149**

Note:

1. The EHR was being developed in 2012-13 and 2013-14; totals from those years would include all users, not just clinical staff.

Source

Alberta Netcare Monthly Utilization Report.

Limitations on the data: Administration staff members who actively access Alberta Netcare are not included in the provided numbers in order to showcase the clinical evidence.

Methodology

Definition/Description: Number of health care professionals with access to the provincial EHR (includes physicians, nurses, pharmacists, medical residents, and allied professionals, but does not include administration and other staff).

Calculation of Results: The calculation only includes clinical staff, such as physicians, nurses, pharmacists, allied professionals as well as three recent additions – chiropractors, dentists and optometrists:
Physicians (including medical residents): 11,347
Nurses: 18,822
Pharmacists: 5,673
Optometrist: 7
Dentists: 18
Chiropractors: 1
Allied Professionals: 6,222

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Performance Indicator 1.a	Emergency visit rate due to substance use (per 100,000 population)				
	RESULTS[1]				
	2012	2013	2014	2015	2016
	586.74	628.34	660.53	694.97	N/A[2]

Notes:
1. The figures for 2012 to 2014 have been corrected.
2. The 2016 result was not available at the time of publication.

Source
Alberta Ambulatory Care database
Alberta Health Care Insurance Plan, Mid-year adjusted Population Registry Files
Statistics Canada, Canadian population, 2011

Methodology
Emergency visits are any hospital discharges beginning with any of the following MIS codes: 71310 (Ambulatory care services described as emergency), 71513 (Community Urgent Care Centre), and 71514 (Community Advanced Ambulatory Care Centre). A discharge (or emergency visit) occurs when a patient leaves the hospital – by death, transfer to another facility, discharge to home, or against medical advice.

Only Alberta residents are included in the numerator. Only the emergency visit rates based on the most responsible diagnosis fields are available. The date of birth and sex on the mid-year population registry file is used to calculate the age and sex of the individual as of June 30 each year. The population excludes members of the Armed Forces, RCMP, inmates in federal penitentiaries, or those who have opted out of the Alberta Health Care Insurance Plan.

Calculation of Results: The crude visit rate is calculated by dividing the number of emergency visits due to substance use for a given age group in a given year, by the total population for a given age in a given year, and multiplying by 100,000.

The crude rates by age group are then converted to an age-standardized rate using the direct method of standardization with weights from the 2011 Canadian population.

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Performance Indicator 1.b	Ambulatory care sensitive conditions: Hospitalization rate for patients under 75 years of age with conditions that could be prevented or reduced if they received appropriate care in an ambulatory setting					
	RESULTS					
	2012	2013	2014	2015	2016	
	369	367	365	349	344[1]	
Note: 1. The 2016 result is preliminary until fall 2017.						

Source

Numerator: Discharge Abstract Database (DAD); Canadian Institute for Health Information (CIHI)
Denominator: Statistics Canada, post-censal population estimate (based on 2011 population)

Methodology

Numerator: Total number of acute care hospitalizations for patients under 75 years of age for ambulatory care sensitive conditions (ACSCs):

- Inclusion Criteria: Any most responsible diagnosis code of grand mal status and other epileptic convulsions, chronic obstructive pulmonary diseases, acute lower respiratory infection, asthma, diabetes, heart failure and pulmonary edema, hypertension, and angina.
- Exclusion Criteria: Individuals 75 years of age and older, death before discharge, admission category recorded as newborn or stillbirth.

Denominator: The denominator is the total mid-year population younger than age 75.

Calculation of Results: Total number of acute care hospitalizations for ACSCs under age 75 years, divided by the total mid-year population under age 75 years, multiplied by 100,000 (age-adjusted using 2011 Canada Census).

A more detailed technical definition for the indicator can be found at:
http://www.health.alberta.ca/documents/PMD-Admissions-Ambulatory-Care-Sensitive-Conditions.pdf

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Performance Measure 2.a	Influenza immunization: Percentage of Albertans who have received the recommended annual influenza immunization • Seniors aged 65 and over • Children aged 6 months to 23 months • Residents of long-term care facilities					
POPULATION	RESULTS					TARGET
	2012-13	2013-14	2014-15	2015-16	2016-17	2016-17
Seniors Aged 65 and over	60%	64%	61%	63%	**62%**	**80%**
Children Aged 6 to 23 months	30%	**34%**	**34%**	36%[1]	**34%**	**80%**
Residents of LTC facilities	89%	88%	90%	90%	**89%**	**95%**

Note:
1. The 2015-16 final result was based on a preliminary report from Alberta Health Services, and has been updated based on the final report.

Source

Numerator: Number of those immunized by age category: Alberta Health Services (AHS) zones; Alberta Health's weekly pharmacists data; First Nations and Inuit Health, Health Canada, Alberta Region

Denominator: For seniors and children, the denominator is the ministry's population estimates, based on mid-year (June 30) registration population estimates. For residents of long-term care facilities the denominator is the number of residents as of December 15, 2016 from Alberta's Interactive Health Data Application.

Methodology

Data is representative of all doses administered up until April 2, 2017. Data are collected during the influenza season, when the influenza vaccine is administered, which is typically October 1 to March 31 each year. However, there may be immunization events that fall outside this range depending on how long the influenza virus circulates in Alberta and which are not included in the immunization rate data.

Data is aggregated by each zone and sent centrally for inclusion into the provincial AHS report. Data includes all immunizations delivered by AHS, community providers including, but not limited to, physician offices, pharmacists, occupational health service providers, long-term care, acute care, student health services at post-secondary institutions, and First Nations Inuit Health Branch.

First Nations people living on-reserve are included. Immunization data is manually collected in each zone by Alberta Health Services.

Calculation of Results:

Seniors aged 65 and over

Immunization rate equals the number of seniors aged 65 years and over who received one dose of the influenza vaccine, divided by the mid-year population estimate of age category, multiplied by 100.

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Children aged 6 to 23 months
Immunization rate equals the number of children aged six months to 23 months who received dose two of two doses, or an annual dose of the influenza vaccine, divided by the mid-year population estimate of age category, multiplied by 100.

Children aged six months to 23 months who require two doses of the influenza vaccine will only be included if they have received two doses during the current season up to and including April 2, 2017. Doses administered between April 1 and 30, 2017, will not be included in 2016-17, but will be included in the next season. Children six to 23 months of age who have received two doses in the past season will be included if they receive an annual (single) dose during the 2016-17 season.

Residents of long-term care facilities
Immunization rate equals the number of residents in long-term care facilities on December 15, 2016, who had received one dose of the influenza vaccine between October 1, 2016, and December 15, 2016, divided by the number of residents in long-term care facilities on December 15, 2016, multiplied by 100. (Note: It is necessary to define the number of residents of long-term care facilities on December 15, due to the high turnover in this population. Otherwise the result would be an immunization rate over 100 per cent).

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Performance Measure 2.b	Childhood immunization rates (by age two) • Diphtheria, tetanus, pertussis, polio, Hib • Measles, mumps, rubella					
IMMUNIZATION	RESULTS[1]					TARGET
	2012	2013	2014	2015	2016	2016
Diphtheria, tetanus, pertussis, polio, Hib	75%	75%	76%	76%	**77%**	**97%**
Measles, mumps, rubella	86%	86%	88%	87%	**88%**	**98%**

Note:

1. Due to retroactive changes to the data sources used for immunization coverage, the previous year's numbers will likely change from current year.

Source

Alberta Health Care Insurance Plan (AHCIP) Quarterly Population Registries
Immunization/Adverse Reactions to Immunization (Imm/ARI)
Alberta Vital Statistics Birth Files

Methodology

Using data from the AHCIP population registries, children born in Alberta are followed through time. Exclusions include individuals leaving Alberta, individuals who died, individuals who do not belong to study period, and First Nations and Lloydminster.

Coverage rates are based on a birth cohort and reported at age two. For example, the 2016 rates relate to the 2014 birth cohort which turned age two in 2016 – the earliest possible time to report coverage by age two.

Once established the population-based birth cohort is linked to Imm/ARI using the Unique Lifetime Identifier and immunization dates.

Calculation of Results: Childhood immunization coverage is calculated using a survival analysis (time-to-immunization) method based on specified population based birth cohort. The analysis measures the probability that the child will receive required vaccines by age two.

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Performance Measure 2.c	Healthy Alberta Trend Index (HATi): Average number of health risk factors per person aged 20 to 64 years					
	RESULTS					TARGET
	2012-13	2013-14	2014-15	2015-16	2016	2016
	2.22	2.12	2.14	N/A[1]	N/A[2]	2.00

Notes:

1. Statistics Canada revised the Canadian Community Health Survey in 2015. Preliminary attempts at the analysis of the data file have identified issues of missing data elements and errors or omissions in the documentation. The department is working with Statistics Canada to resolve these issues.

2. Results were unavailable from Statistics Canada at time of publication.

Source

Statistics Canada, Canadian Community Health Survey: Alberta Share File (not publically issued).

Methodology

The Canadian Community Health Survey (CCHS) has been conducted annually since 2007 and is a cross-sectional survey that collects information related to health status, health care utilization, and health determinants for the Canadian population. The CCHS includes a wide range of questions about the health and health behaviours of residents in each province. The CCHS covers the population 12 years of age and over living in the 10 provinces and the three territories. Excluded from the survey's coverage are persons living on reserves and other Aboriginal settlements in the provinces; full-time members of the Canadian Forces; and, the institutionalized population.

Statistics Canada provides a Provincial Share file to each provincial/territorial health ministry. This file contains detailed survey responses for those participants agreeing to disclosure to the ministry. In Alberta, the share file represents between 92 per cent and 95 per cent of participants in each cycle of the master file.

The calculation of the HATi involves each of the six indicators listed below being dichotomized as 0 or 1 (0 for not having the behavior or 1 for having the behavior) and totaling the results. A HATi of 0 would be most healthy and 6 would be most unhealthy.

1. Life Stress – Respondents self-reporting life stress as extremely or quite a bit stressful.
2. BMI Category – Respondents self-reporting as "overweight" or "obese" (BMI of 25 or higher).
3. Fruit and Vegetable Consumption – Respondents self-reporting having eaten five or more servings of fruit and vegetables per day.
4. Physical Activity – Respondents who are moderately active or active. Category derived from reported physical activities.
5. Smoking Status – Respondents who are current daily smokers.
6. Binge Drinking frequency – Respondents reporting having five or more drinks (for male) or four or more drinks (for female) two or more times per month.

Calculation of Results: Taking into account that Fruit and Vegetable Consumption and Physical Activity are measuring healthy activities, the HATi result equals (Overweight value) plus (1 minus Fruit and Vegetable Consumption value) plus (Daily Smoker value) plus (Binge Drinker value) plus (Life Stress value) plus (1 minus Physical Activity value).

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Performance Indicator 2.a	Life expectancy at birth: Provincial and First Nations				
	RESULTS				
	2012	2013	2014	2015	2016
Provincial	81.68	81.71	81.79	81.87	N/A[1]
First Nation	72.15	72.52	71.60	70.38	N/A[1]
Note: 1. The 2016 results were not available at time of publication.					

Source

Alberta Health Care Insurance Plan
Quarterly Population Registry Files
Alberta Health Postal Code Translation File
Alberta Vital Statistics Death File

Methodology

Life expectancy at birth provides the number of years a given birth cohort would be expected to live if current age and sex mortality rates remained in place.

Life expectancy is calculated using the commonly-used "period" life table methodology. A detailed description of the methodology used to convert age-sex specific death rates into life expectancy at birth can be found in Appendix 3 of the Department of Health report *Chronic Disease Projections Methodology, 2008* (https://open.alberta.ca/publications/9780778566175).

An individual is determined to have First Nations status if ever present on the First Nations Status Registry. The First Nations registry would include anyone ever having registered with the Alberta Health Care Insurance Plan (AHCIP) as either status First Nations or Inuit and would also include some Alberta residents belonging to out-of-province bands. Non-status Indians and Metis cannot be identified in the AHCIP population registry so would not be included. The registry also includes individuals on accounts where the main account holder is First Nations (even though the individual is not).

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Performance Indicator 2.b	Infant mortality rate (per 1,000 live births): Provincial and First Nations				
	RESULTS				
	2012	2013	2014	2015	2016
Provincial	4.10	4.46	4.63	4.39	N/A[1]
First Nation	8.77	9.66	9.56	7.82	N/A[1]
Note: 1. The 2016 results were not available at time of publication.					

Source

Alberta Vital Statistics Death File (infant deaths)
Newborn Metabolic Screening Database (live births)
First Nations Status Registry

Methodology

The infant mortality rate is calculated by dividing the number of infant deaths during a calendar year by the number of live births. Infant deaths are identified from the Alberta Vital Statistics Death file, while live births are identified from the Newborn Metabolic Screening Database.

An individual is determined to have First Nations status if ever present on the First Nations Status Registry. The First Nations registry would include anyone ever having registered with the Alberta Health Care Insurance Plan (AHCIP) as either status First Nations or Inuit and would also include some Alberta residents belonging to out-of-province bands. Non-status Indians and Metis cannot be identified in the AHCIP population registry so would not be included. The registry also includes individuals on accounts where the main account holder is First Nations (even though the individual is not).

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Performance Measure 3.a	Access to primary care through primary care networks: Percentage of Albertans enrolled in a primary care network						
	RESULTS					TARGET	
	2012-13	2013-14	2014-15	2015-16	2016-17	2016-17	
	74%	75%	77%	78%	N/A[1]	79%	

Note:
1. 2016-17 result was not available at time of publication.

Source
Ministry of Health, Alberta Health Care Insurance Plan Statistical Supplement, 2015-16; Claims Assessment System (CLASS).

Methodology
This measure is defined as the percentage of Albertans enrolled in a Primary Care Network (PCN) in the government's fiscal year (April 1 to March 31).

Numerator: The numerator is the total number of patients enrolled in PCNs in a given year as reported in Table 2.29 Primary Care Networks: Distribution of Primary Care Providers, Number of Patients, and total Payments by Alberta Health Services Geographic Zone for the Service Year (April 1 to March 31), Alberta Health Care Insurance Plan Statistical Supplement.

Patients are considered to be enrolled in a PCN if they are assigned to a physician/nurse practitioner/pediatrician registered to a PCN. There are four steps used to assign a patient to a physician (part of the four-cut methodology):

Step 1 Patients who have seen one physician, nurse practitioner, or pediatrician only are assigned to that physician, nurse practitioner, or pediatrician.

Step 2 Patients who have seen more than one physician, but one physician is predominant, are then assigned to that physician.

Step 3 Patients who have seen multiple physicians the same number of times are assigned to the physician who did the physical examination last.

Step 4 Patients who have seen multiple physicians the same number of times, and had no physical examination done, are assigned to the physician who saw the patient last.

The number of patients enrolled in a PCN is calculated by the payments issued to the program, which is associated with the providers within the PCN. The payments to the PCN are identified by the payments the providers receive through the Claims Assessment System (CLASS). CLASS is an application that collects and processes claims transactions for physicians of multiple disciplines, and provides information on compensation for physician services.

Denominator: The denominator is the number of people with an Alberta Personal Health Number that are registered and covered under the Alberta Health Care Insurance Plan as at March 31 of a given year. This number is reported in Table 1.1 of the Alberta Health Care Insurance Plan Statistical Supplement.

Calculation of Results: The percentage of Albertans enrolled in a PCN equals the total number of Albertans informally enrolled in a PCN in a given year, divided by the total population covered by the Alberta Health Care Insurance Plan as at March 31, in the same year, multiplied by 100.

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Performance Measure 4.a	Satisfaction with health care services received: Percentage of Albertans satisfied or very satisfied[1] with health care services personally received in Alberta within the past year					
	RESULTS					TARGET
	2012-13	2013-14	2014-15	2015-16	2016-17	2016-17
	63%	66%	68%	69%	N/A[2]	70%

Note:

1. The question has word anchors for rating 1 (very dissatisfied) and 5 (very satisfied).
2. Results for 2016 are not available. Responses to this telephone survey, conducted by the Health Quality Council of Alberta, have been decreasing over the years and therefore the survey has been discontinued.

Source

Health Quality Council of Alberta. Satisfaction and Experience with Health Care Services: A Survey of Albertans (2010, 2012, 2014, 2016)
Health Quality Council of Alberta. Provincial Survey About Health and the Health System in Alberta (2011, 2013)

Methodology

The calculation of results for this measure is based on the percentage of respondents to the Health Quality Council of Alberta Provincial Survey about Health and the Health System in Alberta 2016 who responded "satisfied" or "very satisfied" to the question:

"Thinking about all of your personal experiences within the past year with the health care services in Alberta that we just reviewed, to what degree are you satisfied or dissatisfied with the services you have received? Please use a scale of 1 to 5 where '1' means 'very dissatisfied' and '5' means 'very satisfied.'"

From February 2, 2016, to March 26, 2016, data were collected through a telephone survey of 1,510 Albertans residing in randomly selected Alberta households. The overall response rate for the survey was calculated at 35 per cent.

A total of 1,360 (weighted total) respondents answered the question on satisfaction with health care services personally received in Alberta within the past year. Results for this question are reliable within ± 2.5 per cent, 19 times out of 20.

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Performance Indicator 4.a	Patient Safety: Percentage of Albertans reporting unexpected harm[1] to self or an immediate family member while receiving health care in Alberta within the past year

RESULTS				
2012-13	**2013-14**	**2014-15**	**2015-16**	**2016-17**
11%	11%	12%	14%	**N/A**[2]

Note:

1. Sometimes when people receive health care, unexpected harm can occur as a result of that care. Such unexpected harm is different from complications which may occur as an expected risk of some treatments.
2. Results for 2016 are not available. Responses to this telephone survey, conducted by the Health Quality Council of Alberta, have been decreasing over the years and therefore the survey has been discontinued.

Source

Health Quality Council of Alberta. Provincial Survey about Health and the Health System in Alberta (2013, 2015, 2016).
Health Quality Council of Alberta. Satisfaction and Experience with Health Care Services in Alberta (2012, 2014).

The provincial population survey is conducted by the Health Quality Council of Alberta (HQCA) for the purpose of obtaining Albertan's views and perceptions on the quality, safety and performance of the publicly funded health care system.

Methodology

Patient safety is defined as the reduction and mitigation of unsafe acts within the health care system rather than from the patient's underlying illness, as well as through the use of best practices shown to improve patient safety outcomes.

Calculation of Results:

Based on the percentage of respondents to the HQCA provincial survey about Health and the Health System in Alberta who responded "yes" to the question:

"To the best of your knowledge, have you, or has a member of your immediate family experienced unexpected harm while receiving healthcare in Alberta within the past year?"

From February 2, 2016, to March 26, 2016, data were collected through a telephone survey of 1,510 Albertans residing in randomly selected Alberta households. The overall response rate for the survey was calculated at 35 per cent.

A total of 1,346 respondents answered the question on experiencing unexpected harm while receiving health care in Alberta within the past year. Results were reliable within ± 1.9 per cent, 19 times out of 20 for this question.

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Performance Indicator 4.b	Emergency department length of stay: Percentage of patients treated and admitted to hospital within eight hours (all sites)				
	RESULTS				
	2012-13	**2013-14**	**2014-15**	**2015-16**	**2016-17**
	55%	54%	48%	49%	**48%**[1]

Note:
1. This result is preliminary until fall 2017.

Source
National Ambulatory Care Reporting System format (NACRS). NACRS sites: all Alberta hospital sites.

Methodology
The Emergency Department (ED) length of stay for admitted patients is measured from the earliest reported time after arrival in the ED (either the triage or registration time) to the time the patient enters the hospital as an inpatient (discharged from the ED). This metric does not apply to Urgent Care facilities as these facilities do not have inpatient spaces. For data sources submitted via abstracting (not operational source systems) the time the patient leaves the ED is determined through investigation of the inpatient visit record.

Calculation of Results: Length of stay is captured in minutes between a Start Time and End Time where the Start Time is the earliest of either the ED Triage Time or the ED Visit (Registration) Time and the End Time is the valid discharge date and time.

The percentage of patients treated and admitted to hospital within eight hours (all sites) equals the number of valid records with a length of stay of less than eight hours (480 minutes), divided by the total number of valid records, multiplied by 100.

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Performance Indicator 4.c	Albertans rating of the quality of health care services received (biennial survey)				
	RESULTS[1]				
	2008	**2010**	**2012**	**2014**	**2016**
	73%	75%	77%	77%	**79%**

Note:
Results for 2008, 2010, 2012, 2014 and 2016 are provided as this indicator is reported every second year.

Source
Health Quality Council of Alberta. Provincial Survey about Health and the Health System in Alberta (2011, 2013, 2015, 2016).
Health Quality Council of Alberta. Satisfaction and Experience with Health Care Services in Alberta (2010, 2012, 2014).

Methodology
This indicator examines Albertans' perceptions of the overall quality of health care services received within the past year.

The calculation of results for this measure is based on the percentage of respondents to the Health Quality Council of Alberta Provincial Survey about Health and the Health System in Alberta 2016 who responded "good" or "excellent" to the question:

"Thinking about all of your personal experiences within the past year with the health care services in Alberta that we just reviewed, how would you describe the overall quality of those services? Excellent, good, fair or poor?"

From February 2, 2016 to March 26, 2016, data were collected through a telephone survey of 1,510 Albertans residing in randomly selected Alberta households. The overall response rate for the survey was calculated at 35 per cent.

A total of 1,360 (weighted total) respondents answered the question on the overall quality of health care services personally received in Alberta within the past year. Results are reliable within ±2.2 per cent, 19 times out of 20, for this question.

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Performance Indicator 4.d	Per capita provincial government health expenditures (actual dollars)					
		RESULTS				
	2012	2013	2014	2015	2016	2017
	4,588	4,618	4,662	4,703[1]	4,793[1]	N/A[1]

Note:

1. Forecast results for the calendar year are available in November of the forecast year. Actual results have a two-year lag.

Source

Canadian Institute of Health Information (CIHI), National Health Expenditure Trends (NHEX), 1975 to 2016.

Methodology

Data is extracted annually from provincial/territorial government public accounts. Programs and/or program items are classified into health expenditure categories according to accepted and standardized methods and definitions used in estimating national health expenditure. Data from the public accounts is supplemented with information from provincial/territorial government department annual reports and annual statistical reports when available, as well as information provided by provincial/territorial government department officials.

Adjustments for regional health authority and/or hospital deficits or surpluses are not made in NHEX unless the provincial government assumes them. If deficits or surpluses are assumed by the provincial government, they are allocated to the years when the regional health authority and/or hospitals accumulated them.

As part of the preparation of this report, CIHI's estimates of provincial/territorial government health expenditures were submitted to provincial/territorial departments of health for review.

To obtain per capita provincial government health expenditure, the provincial government health expenditure is divided by population estimates from the Demography Division of Statistics Canada.

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FINANCIAL INFORMATION

March 31, 2017

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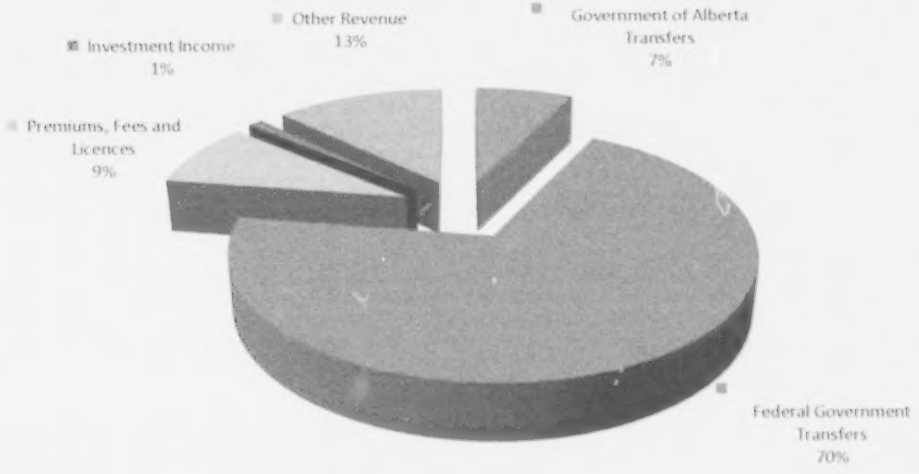
FINANCIAL HIGHLIGHTS

The consolidated Ministry Financial Statements include:

- Department of Health
- Alberta Health Services
- Health Quality Council of Alberta

Consolidated Actual Revenues *(in thousands)*



	2017		2016
	Budget	Actual	Actual
Government of Alberta Transfers	$ 401,000	$ 446,403	$ 408,374
Federal Government Transfers	4,232,570	4,209,342	4,022,961
Premiums, Fees and Licences	561,001	524,716	538,032
Investment Income	66,008	65,558	84,910
Other Revenue	576,231	763,493	734,506
	$ 5,836,810	**$ 6,009,512**	**$ 5,788,783**

Revenues were higher than budgeted by $173 million due to increased transfers from other Government of Alberta ministries; higher than anticipated revenue from pharmaceutical product listings; and increase in recoveries for third party claims and motor vehicle aggregate assessment. This was partially offset by lower fees and charges due to current economic environment resulting in fewer temporary workers requiring healthcare services.

Revenues increased by $221 million compared to prior year mainly due to annual increase in Canada Health Transfer entitlement; and transfers from other Government of Alberta ministries.

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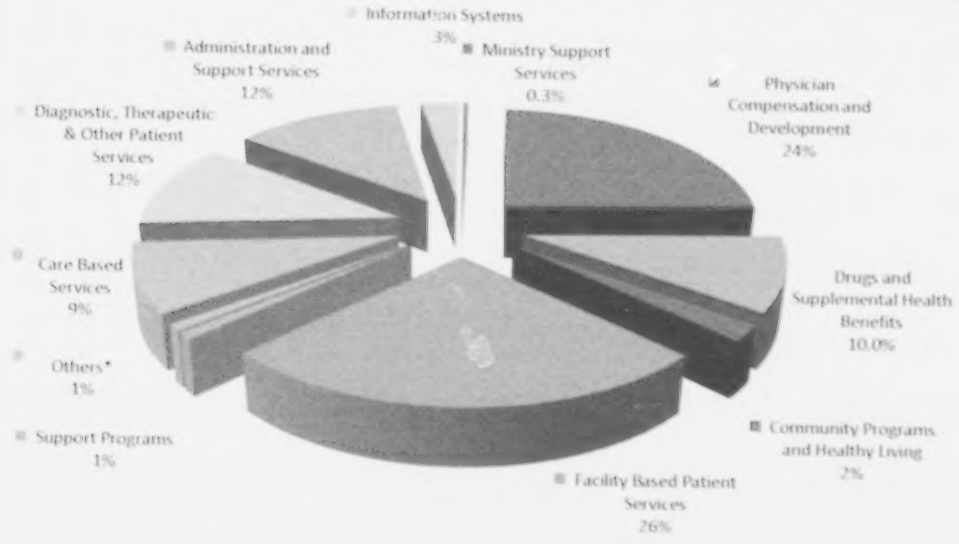
Consolidated Actual Expenses

(in thousands)



	2017 Budget	2017 Actual	2016 Actual
Ministry Support Services	$ 66,899	$ 66,688	$ 63,539
Physician Compensation and Development	4,848,780	5,081,857	4,856,963
Drugs and Supplemental Health Benefits	2,040,246	2,109,530	1,993,992
Community Programs and Healthy Living	496,712	453,187	440,649
Facility-based Patient Services	5,488,000	5,483,736	5,443,094
Care-based Services	2,052,369	1,929,025	1,840,482
Diagnostic, Therapeutic & Other Patient Services	2,394,810	2,388,461	2,325,363
Administration and Support Services	2,389,262	2,586,723	2,478,595
Information Systems	658,123	577,948	637,612
Support Programs	190,814	190,399	172,287
Others*	171,500	182,389	164,754
	$ 20,797,515	$ 21,049,943	$ 20,417,330

* includes Research and Education, Debt Servicing, Cancer Research and Prevention Investment, and Infrastructure Support

Expenses exceeded original budget by $252 million primarily due to physician service volumes; increase in claims, demand for drugs and supplemental health benefits; increase in administration and support services from delays in implementation of planned savings initiatives, increased activities, and higher amortization due to timing of capital expenditure. These increases were partially offset by one-time utilization of accumulated surplus by Primary Care Networks resulting in reduced funding; delayed implementation of budgeted initiatives; and lower amortization due to changes in information system deployment dates.

Expenses increased by $633 million compared to the prior year mainly due to physician compensation and volume increase; increased demand for adult health benefits driven by economic downturn, higher drug utilization due to addition of new cancer drugs and increased demand for specialized drugs; increased capacity under the Community Capacity Plan and Supportive Living Initiatives; compensation from collective agreement settlements and increased amortization from deployment of facilities; and increased activity and contract inflation for laboratory services.

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Alberta Health Services and Health Quality Council of Alberta
Financial Statement Highlights

This section highlights the financial results of Alberta Health Services (AHS) and the Health Quality Council of Alberta (HQCA) for the fiscal year ended March 31, 2017. The financial statements were prepared under Alberta Health's Financial Directives (for AHS only) and Public Sector Accounting Standards.

Alberta Health Services

Operating Results

- AHS finished the year ended March 31, 2017 with a $67 million operating surplus.
- Total revenue increased by 3.7% over 2015-2016 mainly due to an increase in Alberta Health transfers, which accounts for 90% of total revenue.
- Total expenses increased by 2.1% over 2015-2016. Expenses were higher than budgeted primarily due to increased activity resulting from growing demand for health care services, and increased compensation costs resulting from collective bargaining settlements.
- Administration costs in 2016-2017 were $478 million, or 3.3% of total expenses. 2015--2016 administration costs were $434 million, or 3.1% of total expenses.
- AHS employed 78,434 Full-Time-Equivalents as of March 31, 2017.

Financial Position

- AHS' accumulated surplus at March 31, 2017 was $1,226 million and consists of four main components: unrestricted surplus, internally restricted surplus for future purposes, invested in tangible capital assets, and endowments.

Health Quality Council of Alberta

Operating Results

- For fiscal 2016-2017 HQCA reported an operating deficit of $532 thousand, compared to a prior year deficit of $705 thousand. The deficit was mainly due to implementing projects that were delayed in previous years and carried over to 2016-2017, including undertaking of the Laboratory Services Review and Continuity of Care projects.
- 2016-2017 expenses were $7.5 million, compared to $7.4 million in the prior year – a 1.4% increase overall.
- HQCA employed 33 Full-Time-Equivalents as of March 31, 2017.

Financial Position

- At March 31, 2017, HQCA reported net assets of $1.4 million.
- HQCA reported tangible capital assets of $1.1 million at March 31, 2017, compared to $1.2 million in the prior year.

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FINANCIAL INFORMATION
Ministry of Health

Consolidated Financial Statements
March 31, 2017

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Ministry of Health

Consolidated Financial Statements

Year Ended March 31, 2017

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Consolidated Financial Statements
March 31, 2017

Auditor's Report

Consolidated Statement of Operations

Consolidated Statement of Financial Position

Consolidated Statement of Change in Net Debt

Consolidated Statement of Cash Flows

Notes to the Consolidated Financial Statements

Schedule 1 - Consolidated Revenues

Schedule 2 - Consolidated Expenses - Directly Incurred Detailed by Object

Schedule 3 - Consolidated Related Party Transactions

Schedule 4 - Consolidated Allocated Costs

Schedule 5 - Consolidated Portfolio Investments

Schedule 6 - List of Entities included in the Consolidated Financial Statements

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AUDITOR GENERAL
Alberta

Independent Auditor's Report

To the Members of the Legislative Assembly

Report on the Consolidated Financial Statements

I have audited the accompanying consolidated financial statements of the Ministry of Health, which comprise the consolidated statement of financial position as at March 31, 2017, and the consolidated statements of operations, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on these consolidated financial statements based on my audit. I conducted my audit in accordance with Canadian generally accepted auditing standards. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

In my opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Ministry of Health as at March 31, 2017, and the results of its operations, its changes in net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

[Original signed by Merwan N. Saher FCPA, FCA]

Auditor General

June 2, 2017

Edmonton, Alberta

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Consolidated Statement of Operations

Year Ended March 31, 2017

(in thousands)

	2017 Budget	2017 Actual	2016 Actual (Restated - Note 3)
Revenues (Schedule 1)			
Government Transfers	$ 401,000	$ 446,403	$ 408,374
Government of Alberta Transfers	4,232,570	4,209,342	4,022,961
Federal Government Transfers	561,001	524,716	538,032
Premiums, Fees and Licences	66,008	65,558	84,910
Investment Income	576,231	763,493	734,506
Other Revenue	5,836,810	6,009,512	5,788,783
Expenses - Directly Incurred (Note 2b(ii) and Schedules 2 & 4)			
Ministry Support Services	66,899	66,688	63,539
Physician Compensation and Development	4,848,780	5,081,857	4,856,963
Drugs and Supplemental Health Benefits	2,040,246	2,109,530	1,993,992
Community Programs and Healthy Living	496,712	453,187	440,649
Facility-based Patient Services	5,488,000	5,483,736	5,443,094
Care-based Services	2,052,369	1,929,025	1,840,482
Diagnostic, Therapeutic & Other Patient Services	2,394,810	2,388,461	2,325,363
Administration and Support Services	2,389,262	2,586,723	2,478,595
Information Systems	658,123	577,948	637,612
Support Programs	190,814	190,399	172,287
Research and Education	99,000	98,630	94,088
Debt Servicing	17,000	16,221	15,373
Cancer Research and Prevention Investment	12,500	8,270	5,000
Infrastructure Support	43,000	59,268	50,293
	20,797,515	21,049,943	20,417,330
Annual Deficit	$ (14,960,705)	$ (15,040,431)	$ (14,628,547)

The accompanying notes and schedules are part of these consolidated financial statements.

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CONSOLIDATED STATEMENT OF FINANCIAL POSITION

As at March 31, 2017
(in thousands)

	2017	2016 (Restated - Note 3)
Financial Assets		
Cash	$ 73,747	$ 81,775
Accounts Receivable (Note 4)	455,465	487,626
Portfolio Investments		
- Operating (Schedule 5)	2,128,132	2,077,933
- Endowments (Note 11 and Schedule 5)	74,710	75,966
	2,732,054	2,723,300
Liabilities		
Accounts Payable and Accrued Liabilities (Note 5)	2,343,603	2,362,173
Deferred Revenue (Note 6)	252,653	247,733
Unspent Deferred Capital Contributions (Note 6)	98,248	90,401
Debt (Note 7)	320,087	326,909
	3,014,591	3,027,216
Net Debt	(282,537)	(303,916)
Non-Financial Assets		
Tangible Capital Assets (Note 8)	7,686,024	7,646,188
Inventories of Supplies	107,366	116,249
Prepaid Expenses	116,044	116,170
	7,909,434	7,878,607
Net Assets Before Spent Deferred Capital Contributions	7,626,897	7,574,691
Spent Deferred Capital Contributions (Note 6)	6,302,448	6,248,856
Net Assets	$ 1,324,449	$ 1,325,835
Net Assets, Beginning of Year	$ 1,325,835	$ 1,442,229
Annual Deficit	(15,040,431)	(14,628,547)
Net Financing Provided from General Revenues	15,039,045	14,512,153
Net Assets, End of Year	$ 1,324,449	$ 1,325,835

Contractual Obligations and Contingent Liabilities (Notes 9 and 10)

The accompanying notes and schedules are part of these consolidated financial statements.

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CONSOLIDATED STATEMENT OF CHANGE IN NET DEBT

Year Ended March 31, 2017

(in thousands)

	2017		2016
	Budget	Actual	Actual (Restated - Note 3)
Annual Deficit	$ (14,960,705)	$ (15,040,431)	$ (14,628,547)
Acquisition of Tangible Capital Assets (Note 8)	(914,770)	(609,785)	(662,551)
Amortization of Tangible Capital Assets (Note 8)	605,281	569,377	607,794
Write-down of Tangible Capital Assets		572	480
Acquisition of Inventories of Supplies	(756,000)	(839,659)	(842,876)
Consumption of Inventories of Supplies	753,700	841,894	846,265
Write-down of Inventories of Supplies		6,648	1,257
Change in Prepaid Expenses		126	10,209
Change in Spent Deferred Capital Contributions (Note 6)		53,592	218,289
Net Financing Provided from General Revenues		15,039,045	14,512,153
Decrease in Net Debt		21,379	62,473
Net Debt, Beginning of Year		(303,916)	(366,389)
Net Debt, End of Year		$ (282,537)	$ (303,916)

The accompanying notes and schedules are part of these consolidated financial statements.

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CONSOLIDATED STATEMENT OF CASH FLOWS

Year Ended March 31, 2017

(in thousands)	2017	2016 (Restated - Note 3)
Operating Transactions		
Annual Deficit	$ (15,040,431)	$ (14,628,547)
Non-cash items:		
Amortization of Tangible Capital Assets (Note 8)	569,377	607,794
Spent Deferred Capital Contributions recognized as Revenue (Note 6)	(323,348)	(319,001)
Write-down of Tangible Capital Assets / Inventories of Supplies	7,220	1,737
Valuation Adjustments	72,638	57,622
Realized Gain on Sale of Portfolio Investments	(9,531)	(15,048)
	(14,724,075)	(14,295,443)
(Increase) in Accounts Receivable	(7,150)	(148,657)
(Decrease) in Accounts Payable and Accrued Liabilities	(51,897)	(135,337)
(Decrease) in Deferred Revenue	(38,845)	(27,756)
Decrease in Inventories of Supplies	2,235	3,389
Decrease in Prepaid Expenses	126	10,209
Cash (applied to) Operating Transactions	(14,819,606)	(14,593,595)
Capital Transactions		
Acquisition of Tangible Capital Assets (Note 8)	(393,852)	(262,559)
Cash (applied to) Capital Transactions	(393,852)	(262,559)
Investing Transactions		
Purchase of Portfolio Investments	(3,339,338)	(4,230,911)
Proceeds on Disposal of Portfolio Investments	3,299,926	4,148,996
Cash (applied to) Investing Transactions	(39,412)	(81,915)
Financing Transactions		
Net Financing provided from General Revenues	15,039,045	14,512,153
Restricted Capital Contribution received	213,839	172,781
Restricted Capital Contribution returned	(1,220)	(4,700)
Debt Retirement	(16,822)	(15,226)
Debt Issues	10,000	20,300
Cash provided by Financing Transactions	15,244,842	14,685,308
(Decrease) in Cash	(8,028)	(252,761)
Cash, Beginning of Year	81,775	334,536
Cash, End of Year	$ 73,747	$ 81,775

The accompanying notes and schedules are part of these consolidated financial statements.

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NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2017

Note 1 Authority and Purpose

The Minister of Health (Minister) has been designated as responsible for various Acts by the *Government Organization Act*, Chapter G-10, revised Statutes of Alberta 2000 and its regulations. Following are the organizations that comprise the Ministry of Health (Ministry) and the authority under which each organization operates.

Department of Health	*Government Organization Act*
Alberta Health Services	*Regional Health Authorities Act*
Health Quality Council of Alberta	*Health Quality Council of Alberta Act*

In support of the Government of Alberta's commitments for a stable and improved public health care system, the Ministry is to ensure that Albertans receive the right health care services, at the right time, in the right place, provided by the right health care providers and teams.

Note 2 Summary of Significant Accounting Policies and Reporting Practices

These consolidated financial statements are prepared in accordance with Canadian Public Sector Accounting Standards (PSAS).

(a) Reporting Entity and method of consolidation

The reporting entity is the Ministry of Health, for which the Minister of Health is accountable. The accounts of the Department are fully consolidated with the entities listed in Schedule 6 on a line-by-line basis.

The accounts of government sector entities, except those designated as government business enterprises, are consolidated using the line-by-line method. Under this method, accounting policies of the consolidated entities are adjusted to conform to government accounting policies and the results of each line item in their financial statements (revenue, expense, assets, and liabilities) are included in government's results. Revenue and expense, capital, investing and financing transactions and related asset and liability balances between the consolidated entities have been eliminated.

(b) Basis of Financial Reporting

(i) Revenues

All revenues are reported on the accrual basis of accounting. Cash received for which goods or services have not been provided by year end is recognized as unearned revenue and included in accounts payable.

Investment income earned from restricted sources is deferred and recognized when the stipulations imposed have been met. Gains and losses on portfolio investments are not recognized in the Consolidated Statement of Operations until realized.

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Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

Government Transfers

Transfers from all governments are referred to as government transfers.

Government transfers and the associated externally restricted investment income are recognized as deferred capital contributions or deferred revenue if the eligibility criteria for use of the transfer, or the stipulations together with the Ministry's actions and communications as to the use of the transfer, create a liability. These transfers are recognized as revenue as the stipulations are met and, when applicable, the Ministry complies with its communicated use of these transfers.

All other government transfers, without stipulations for the use of the transfer, are recognized as revenue when the transfer is authorized and the Ministry meets the eligibility criteria (if any).

Donations and Non-Government Grants

Donations and non-government grants are received from individuals, corporations, and private sector not-for-profit organizations. Donations and non-government grants may be unrestricted or externally restricted for operating or capital purposes. Unrestricted donations and non-government grants are recognized as revenue in the year received or in the year the funds are committed and the amounts can be reasonably estimated. Externally restricted donations, non-government grants, and realized gains and losses for the associated externally restricted investment income are recognized as deferred revenue if the terms for their use, or the terms along with the Ministry's actions and communications as to the use, create a liability. These resources are recognized as revenue as the terms are met and, when applicable, the Ministry complies with its communicated use.

Grants and Donations for Land

The Ministry recognizes transfers and donations for the purchase of land as a liability when received, and as revenue when the Ministry purchases the land. The Ministry recognizes in-kind contributions of land as revenue at the fair value of the land. When the Ministry cannot determine the fair value, it records such in-kind contributions at a nominal value.

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Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(ii) Expenses

Directly Incurred

Directly incurred expenses are those costs the Ministry has primary responsibility and accountability for.

In addition to program operating expenses such as grants, salaries, supplies etc., directly incurred expenses also include:

- amortization of tangible capital assets;
- consumption of inventories of supplies;
- pension costs which comprise the cost of employer contributions for current service of employees during the year; and
- valuation adjustments which include changes in the valuation allowances used to reflect financial assets at their net recoverable or other appropriate value. Valuation adjustments also represent the change in management's estimate of future payments arising from obligations relating to vacation and sick pay.

Grants are recognized as expenses in the period the transfer is authorized and all eligibility criteria have been met by the recipient.

Incurred by Others

Services contributed by other related entities in support of the Ministry's operations are not recognized and are disclosed in Schedule 4 to show the full cost.

(iii) Valuation of Financial Assets and Liabilities

Fair value is the amount of consideration agreed upon in an arm's length transaction between knowledgeable, willing parties who are under no compulsion to act.

The fair values of cash, accounts receivable, and accounts payable and accrued liabilities are estimated to approximate their carrying values because of the short-term nature of these instruments.

(iv) Financial Assets

Financial assets are assets that could be used to discharge existing liabilities or finance future operations and are not for consumption in the normal course of operations.

Financial assets are the Ministry's financial claims on external organizations and individuals at the year end.

Cash

Cash comprises of cash on hand.

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Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

Accounts Receivable

Accounts receivable are recognized at the lower of cost or net recoverable value. Valuation allowance is recorded when recovery is uncertain.

Portfolio Investments

Portfolio investments are recorded at cost, or amortized cost, less any write-downs associated with a loss in value that is other than a temporary decline. A write-down of a portfolio investment to reflect a loss in value is not reversed for a subsequent increase in value. Gains and losses on investments are recognized when an investment is sold or when there is a permanent impairment in the value of an investment.

Endowments are included in Financial Assets in the Consolidated Statement of Financial Position. Donors have placed restrictions on their contributions to endowments, for example capital preservation. The principal restriction is that the original contribution should be maintained intact in perpetuity. Other restrictions may include spending investment income earned by endowments for specific operational or capital purposes, or capitalizing a certain amount of investment income to maintain and grow the real value of endowments.

(v) Liabilities

Liabilities represent present obligations of the Ministry to external organizations and individuals arising from transactions or events occurring before the year end. They are recognized when there is an appropriate basis of measurement and management can reasonably estimate the amount.

Liabilities also include:
- all financial claims payable by Ministry at the year end;
- accrued employee vacation entitlements; and
- contingent liabilities where future liabilities are likely.

Debt

Debentures and other debt are recognized at their face amount less unamortized discount, which includes issue expenses.

(vi) Non-Financial Assets

Non-financial assets are limited to tangible capital assets, inventories of supplies and prepaid expenses.

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Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

Tangible Capital Assets

Tangible capital assets of the Ministry are recorded at historical cost and amortized on a straight-line basis over the estimated useful lives of the assets. Costs incurred and reported by the Ministry of Infrastructure to build tangible capital assets on behalf of AHS are recorded as work in progress and spent deferred capital contributions. The threshold for capitalizing new systems development is $250,000 and the threshold for major enhancements is $100,000. The threshold for all other tangible capital assets is $5,000. All land is capitalized.

Amortization is only charged if the tangible capital asset is put into service.

Inventories of Supplies

Inventories of supplies for consumption or distribution at no charge are valued at the lower of cost (defined as moving average cost) and replacement cost.

Prepaid Expenses

Prepaid expenses are recognized at cost and amortized based on the terms of the agreement.

Assets acquired by right are not included.

(vii) Foundations

Various foundations have been established under the *Regional Health Authorities Act* for the purpose of raising funds to enhance health care in various communities throughout Alberta. Depending on how the foundations are established, the Ministry either controls the foundations or has an economic interest in them. Foundations that are controlled by the Ministry are consolidated in these consolidated financial statements.

(viii) Measurement Uncertainty

Measurement uncertainty exists when there is a variance between the recognized or disclosed amount and another reasonably possible amount. Measurement uncertainty that is material to these financial statements exists in the accrual of the Canada Health Transfer.

Canada Health Transfer entitlements are determined on an equal per capita cash basis. Measurement uncertainty for the Canada Health Transfer relates to the population estimate upon which entitlements are based. As the population estimate is finalized, it is used to adjust the entitlements of open prior years. Accordingly, these amounts are estimated and could change by a material amount.

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Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(c) Future Accounting Changes

The Public Sector Accounting Board has issued the following accounting standards:

- **PS 2200 Related Party Disclosures and PS 3420 Inter-Entity Transactions (effective April 1, 2017)**
  PS 2200 defines a related party and establishes disclosures required for related party transactions; PS 3420 establishes standards on how to account for and report transactions between public sector entities that comprise a government's reporting entity from both a provider and recipient perspective.

- **PS 3210 Assets, PS 3320 Contingent Assets, and PS 3380 Contractual Rights (effective April 1, 2017)**
  PS3210 provides guidance for applying the definition of assets set out in FINANCIAL STATEMENT CONCEPTS, Section PS 1000, and establishes general disclosure standards for assets; PS 3320 defines and establishes disclosure standards on contingent assets; PS 3380 defines and establishes disclosure standards on contractual rights.

- **PS 3430 Restructuring Transactions (effective April 1, 2018)**
  This standard provides guidance on how to account for and report restructuring transactions by both transferors and recipients of assets and/or liabilities, together with related program or operating responsibilities.

- **PS 3450 Financial Instruments (effective April 1, 2019)**
  The Ministry has not yet adopted this standard and has the option of adopting it in fiscal year 2019-20 or earlier. Adoption of this standard requires corresponding adoption of: PS 2601, Foreign Currency Translation; PS 1201, Financial Statement Presentation; and PS 3041, Portfolio Investments in the same fiscal period. These standards provide guidance on: recognition, measurement, and disclosure of financial instruments; standards on how to account for and report transactions that are denominated in a foreign currency; general reporting principles and standards for the disclosure of information in financial statements; and how to account for and report portfolio investments.

  Management is currently assessing the impact of these standards on the financial statements.

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Note 3 Program Transfers

Effective April 1, 2016:

- The responsibility for the operational funding of Alberta Innovates – health solutions was transferred to the Ministry of Economic Development and Trade.
- The responsibility for the administration of Continuing Care Beds was transferred from the Ministry of Seniors and Housing.
- The responsibility for funding the Health Workforce Action Plan was transferred from the Ministry of Labour.

Comparatives for 2016 have been restated as if the Ministry had always been assigned with its current responsibilities.

Net assets on April 1, 2015 are made up as follows:

Net assets as previously reported	$ 1,538,889
Transfer to the Ministry of Economic Development and Trade	(75,560)
Transfer from the Ministry of Seniors and Housing	(21,058)
Transfer from the Ministry of Labour	(42)
Net assets at April 1, 2015	$ 1,442,229

Note 4 Accounts Receivable
(in thousands)

	2017			2016 (Restated - Note 3)
	Gross Amount	Allowance for Doubtful Accounts	Net Realizable Value	Net Realizable Value
Accounts Receivable	$ 480,628	$ (25,163)	$ 455,465	$ 487,626

Accounts receivable are unsecured and non-interest bearing.

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Note 5 Accounts Payable and Accrued Liabilities
(in thousands)

	2017	2016 (Restated - Note 3)
Accounts Payable and Accrued Liabilities	$ 1,647,065	$ 1,696,413
Employee Future Benefits	664,897	631,570
Capital Lease Obligations [a]	31,641	34,190
	$ 2,343,603	$ 2,362,173

[a] Capital Lease Obligations includes a site lease with the University of Calgary, a site lease in Peace River, and vehicle leases.

Principal repayment requirements in each of the next five years and thereafter are as follows:

	Capital Lease Obligations
2017-18	$ 3,889
2018-19	3,388
2019-20	2,909
2020-21	2,731
2021-22	2,754
Thereafter	27,772
Less: amount representing interest under leases	(11,802)
	$ 31,641

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Note 6 Deferred Contributions
(in thousands)

	2017	2016 (Restated - Note 3)
Deferred Revenue [i]	$ 252,653	$ 247,733
Unspent Deferred Capital Contributions [ii]	98,248	90,401
Spent Deferred Capital Contributions [iii]	6,302,448	6,248,856
	$ 6,653,349	$ 6,586,990

(i) Deferred revenue represents unexpended external resources with stipulations relating to operating expenditure. Changes in balances in deferred revenue are as follows:

	2017				2016
	Federal government	Government of Alberta	Other	Total	(Restated - Note 3) Total
Balance, beginning of year	$ 550	$ 24,503	$ 222,680	$ 247,733	$ 239,088
Received/receivable during the year	10,200	72,547	134,351	217,098	198,877
Restricted realized investment income	-	1,645	5,821	7,466	6,375
Transferred from (to) unspent deferred capital contributions	-	60,529	(16,764)	43,765	36,401
Recognized as revenue during the year	(4,167)	(114,141)	(145,101)	(263,409)	(233,008)
Balance, end of year	$ 6,583	$ 45,083	$ 200,987	$ 252,653	$ 247,733

(ii) Unspent deferred capital contributions represent unspent external resources with stipulations related to the purchase of tangible capital assets. Changes in balances in unspent deferred capital contributions are as follows:

	2017			2016
	Government of Alberta	Other	Total	(Restated - Note 3) Total
Balance, beginning of year	$ 9,174	$ 81,227	$ 90,401	$ 96,019
Received/receivable during the year	184,390	29,449	213,839	172,739
Transferred tangible capital assets	215,933	-	215,933	399,992
Restricted realized investment income	-	-	-	42
Contributions returned	-	(1,220)	(1,220)	(4,700)
Transferred (to) from deferred revenue	(60,529)	16,764	(43,765)	(36,401)
Transferred to spent deferred capital contributions	(333,011)	(43,929)	(376,940)	(537,290)
Balance, end of year	$ 15,957	$ 82,291	$ 98,248	$ 90,401

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Note 6 Deferred Contributions (continued)
(in thousands)

(iii) Spent deferred capital contributions represent resources which have been spent for acquisition of tangible capital assets stipulated to be used over their useful life. Revenue is recognized over the useful life of the assets. Changes in balances in spent deferred capital contributions are as follows:

	2017			2016
	Government of Alberta	Other	Total	(Restated - Note 3) Total
Balance, beginning of year	$ 6,056,411	$ 192,445	$ 6,248,856	$ 6,030,567
Transferred from unspent deferred capital contributions	333,011	43,929	376,940	537,290
Recognized as revenue during the year	(278,112)	(45,236)	(323,348)	(319,001)
Balance, end of year	$ 6,111,310	$ 191,138	$ 6,302,448	$ 6,248,856

Note 7 Debt
(in thousands)

	2017			2016
	Maturity	Interest Rate	Book Value	Book Value
Debentures [a]	2021 to 2038	2.42-4.93%	$ 318,875	$ 325,430
Other			1,212	1,479
Total			$ 320,087	$ 326,909

[a] The debentures have been issued by AHS to the Alberta Capital Finance Authority.

Principal repayment requirements in each of the next five years and thereafter are as follows:

	Debentures and Other Debt
2017-18	$ 17,612
2018-19	22,133
2019-20	23,091
2020-21	24,092
2021-22	24,800
Thereafter	208,359
	$ 320,087

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Note 8 Tangible Capital Assets
(in thousands)

	2017							2016
	Land	Buildings[1]	Land Improvements	Equipment	Computer Hardware and Software	Leasehold Assets	Total	(Restated - Note 3) Total
Estimated Useful Life	Indefinite	10-40 years	5-40 years	3-20 years	3-10 years	Term of Lease		
Historical Cost[2]								
Beginning of year	$ 110,068	$10,123,570	$ 70,918	$ 2,166,681	$ 1,580,779	$ 236,638	$ 14,288,654	$ 13,790,673
Additions[3]	688	332,948	11,907	155,912	104,432	3,898	609,785	662,551
Disposals, including write-downs	(167)	(2,681)	(61)	(30,343)	(11,451)	(1,140)	(45,843)	(164,570)
	110,589	10,453,837	82,764	2,292,250	1,673,760	239,396	14,852,596	14,288,654
Accumulated Amortization								
Beginning of year	-	3,511,911	60,285	1,668,583	1,240,273	161,414	6,642,466	6,198,762
Amortization expense	-	268,653	2,813	154,969	129,371	13,571	569,377	607,794
Effect of disposals	-	(2,675)	(61)	(29,962)	(11,450)	(1,123)	(45,271)	(164,090)
	-	3,777,889	63,037	1,793,590	1,358,194	173,862	7,166,572	6,642,466
Net Book Value at March 31, 2017	$ 110,589	$ 6,675,948	$ 19,727	$ 498,660	$ 315,566	$ 65,534	$ 7,686,024	
Net Book Value at March 31, 2016	$ 110,068	$ 6,611,659	$ 10,633	$ 498,098	$ 340,506	$ 75,224		$ 7,646,188

(1) Buildings include parking lots.

(2) Historical cost includes work-in-progress at March 31, 2017 totaling $924,754 (2016 - $1,094,501).

(3) Additions include total transferred capital assets of $215,933 (2016 - $399,992) from Ministry of Infrastructure.

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Note 9 Contractual Obligations
(in thousands)

Contractual obligations are obligations of the Ministry to others that will become liabilities in the future when the terms of those contracts or agreements are met. As at March 31, 2017, the Ministry has the following contractual obligations:

	2017	2016 (Restated - Note 3)
Specific Program Commitments	$ 434,353	$ 386,354
Capital Contracts	158,911	80,866
Service Contracts and Operating Leases	408,768	405,347
	$ 1,002,032	$ 872,567

The aggregate amounts payable for the unexpired terms of these contractual obligations are as follows:

	Specific Program Commitments	Capital Contracts	Service Contracts and Operating Leases	Total
2017-18	$ 369,808	$ 119,725	$ 119,034	$ 608,567
2018-19	61,589	39,186	82,285	183,060
2019-20	1,309	-	71,319	72,628
2020-21	633	-	35,485	36,118
2021-22	507	-	31,430	31,937
Thereafter	507	-	69,215	69,722
	$ 434,353	$ 158,911	$ 408,768	$ 1,002,032

Canadian Blood Services

The Government of Alberta is committed to provide funding to the Canadian Blood Services (CBS) for the provision of blood services in Canada. This commitment was outlined in a Memorandum of Understanding, signed in January 1998, which recorded the understandings and commitments of the Minister of Health of Canada and the Provincial and Territorial Ministers of Health (except Quebec) regarding their respective roles and responsibilities in a renewed national blood system.

Alberta's obligation for the operational costs of CBS is determined on a per capita basis, and the costs for fractionated blood and blood products is determined on the basis of annual utilization of these products. During the year, payments to CBS amounted to $196,000 (2016 - $191,000).

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Note 10 Contingent Liabilities and Equity Agreements
(in dollars)

Equity Agreements with Voluntary Hospital Owners

The Ministry has a contingent liability for buy-out of equity under Equity Agreements entered into between the Ministry and Voluntary Hospital Owners. The Ministry's payout liability is contingent upon notification by the voluntary hospital owner of termination of the equity agreement. At March 31, 2017, the contingent payout liability upon termination is estimated at $12.8 million (2016 - $12.8 million).

Other Contingent Liabilities

The Ministry has been named in 190 (2016: 183) claims of which the outcome are not determinable. Of these claims, 180 (2016: 165) have specified amounts totalling $396.1 million (2016: $326.9 million). The resolution of indeterminable claims may result in a liability, if any, that may be significantly lower than the claimed amount.

The Ministry has been named as a co-defendant in a certified Class Action (the Claim) arising from increases to long-term accommodation charges, implemented by Alberta Government regulations enacted on and after August 1, 2003, and paid by residents of long-term care facilities. The amount of the Claim has not yet been specified.

Indemnity

As described in Note 9, CBS provides blood services in Alberta. CBS has established two wholly-owned captive insurance corporations, CBS Insurance Company Limited (CBSI) and Canadian Blood Services Captive Insurance Company Limited (CBSE). CBSI provides insurance coverage up to $250 million with respect to risks associated with the operation of the blood system.

CBSE was capitalized in whole through funding from the provinces and territories (except Quebec), through a Captive Support Agreement dated September 28, 2006 ("CSA"), between the provinces, territories, and CBSE. Under the CSA, each of the provinces and territories provided their Pro Rata Share (as defined in the CSA) through an indemnity. Alberta's Pro Rata Share is 13.1% of CBSE's total capital amount, which amounts to $98.0 million. Authority for Alberta to provide the indemnity under the CSA is pursuant to section 5.05 of the Indemnity Authorization Regulation 22/1997, under the *Financial Administration Act*.

The expense recognition criterion for the indemnity is notification from CBS that the indemnity is required. At March 31, 2017, no amount has been recognized for this indemnity.

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Note 11 Endowment Funds
(in thousands)

	2017	2016
Balance, beginning of year	$ 75,966	$ 72,381
Endowment contributions	1,308	3,585
Reclassification of endowments	(2,564)	-
Balance, end of year	$ 74,710	$ 75,966

Note 12 Payments under Reciprocal and Other Agreements
(in thousands)

The Ministry entered into agreements, under the Alberta Health Care Insurance Plan, with other Provincial and Territorial Governments to provide health services on their behalf. The Ministry pays service providers for services rendered under the agreements and recovers the amount paid from the program sponsors. Service providers include Alberta Health Services and physicians. Costs under these agreements are incurred by the Ministry under authority in section 25 of the *Financial Administration Act*.

In addition, Alberta undertook the role as lead province for the Health Support Committee effective October 19, 2016 to October 19, 2017. The primary focus of the role is to provide secretariat functions for the activities and initiatives.

Accounts receivable includes $46,508 (2016 - $31,673) and accounts payable includes $216 (2016 - $0).

Amounts paid under agreements with program sponsors are as follows:

	2017	2016
Other Provincial and Territorial Governments	$ 298,807	$ 308,559
Health Support Committee	216	-
	$ 299,023	$ 308,559

Note 13 Trust Funds under Administration
(in thousands)

Trust funds under administration are funds consisting of public money over which the Legislature has no power of appropriation. Because the Ministry has no equity in the funds and administers them for the purposes of various trusts, they are not included in the consolidated financial statements. At December 31, 2016, the Health Benefit Trust of Alberta reported fund balance of $78,183 (2015 - $97,502). At March 31, 2017, fund balance held by other trust funds is $2,231 (2015 - $5,542).

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Note 14 Benefit Plans
(in thousands)

Except as noted below, the Ministry participates in the multi-employer pension plans: Management Employees Pension Plan, Public Service Pension Plan, Local Authorities Pension Plan, and Supplementary Retirement Plan for Public Service Managers. The expense for these pension plans is equivalent to the employer's annual contributions.

AHS also participates in Supplemental Pension Plan and Group Registered Retirement Savings Plans (GRRSPs) which are defined contribution plans for certain employee groups.

AHS and HQCA participate in Supplemental Executive Retirement Plan (SERP) which provides future pension benefits to participants based on years of service and earnings. AHS has closed SERP for new entrants since April 1, 2009. At March 31, 2017, the plan has net accrued benefit liability of $2,734 (2016-$909) which is reported in accounts payable and accrued liabilities.

At December 31, 2016, the Management Employees Pension Plan reported a surplus of $402,033 (2015 – surplus $299,051), the Public Service Pension Plan reported a surplus of $302,975 (2015 – deficiency $133,188), the Local Authorities Pension Plan reported a deficiency of $637,357 (2015 - $923,416) and the Supplementary Retirement Plan for Public Service Managers had a deficiency of $50,020 (2015 – deficiency $16,305).

The Ministry's pension expense for the year is as follows:

	2017	2016 (Restated - Note 3)
Registered Benefit Plans	$ 609,790	$ 584,479
Supplemental Executive Retirement Plans	2,265	(762)
Supplemental Pension Plan and GRRSPs	50,627	48,645
	$ 662,682	$ 632,362

The Ministry also participates in two multi-employer Long Term Disability Income Continuance Plans. At March 31, 2017, the Bargaining Unit Plan reported an actuarial surplus of $101,515 (2016 - $83,066) and the Management, Opted Out and Excluded Plan reported an actuarial surplus of $31,439 (2016 - $29,246). The expense for these two plans is limited to the employer's annual contributions for the year.

Note 15 Comparative Figures

Certain 2016 figures have been reclassified to conform to the 2017 presentation.

Note 16 Approval of Financial Statements

The deputy minister and the senior financial officer approve these financial statements.

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Schedules to the Consolidated Financial Statements

Year Ended March 31, 2017

Schedule 1
Consolidated Revenues
(in thousands)

	2017	2016 (Restated - Note 3)
Government of Alberta Transfers		
Alberta Cancer Prevention Legacy Fund	$ 22,174	$ 23,000
Other Government Departments	424,229	385,374
	446,403	408,374
Federal Government Transfers		
Canada Health Transfer	4,200,830	4,013,942
Other	8,512	9,019
	4,209,342	4,022,961
Premiums, Fees and Licences		
Fees and Charges	479,182	491,489
Supplementary Health Benefit Premiums	45,534	46,543
	524,716	538,032
Investment Income	65,558	84,910
Other Revenue		
Ancillary operations	135,660	133,220
Donations	163,155	163,221
Previous years' refunds of expenditure	10,128	28,177
Product Listing Agreements	110,667	107,911
Third Party Recoveries	150,515	129,056
Miscellaneous	193,368	172,921
	763,493	734,506
	$ 6,009,512	$ 5,788,783

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Schedules to the Consolidated Financial Statements

Year Ended March 31, 2017

Schedule 2

Consolidated Expenses - Directly Incurred Detailed by Object

(in thousands)

	2017	2016 (Restated - Note 3)
Grants	$ 6,365,550	$ 6,043,408
Supplies and Services	5,119,800	5,023,816
Salaries, Wages and Employee Benefits	8,090,505	7,846,945
Amortization of Tangible Capital Assets	569,377	607,794
Consumption of Inventories of Supplies	841,894	846,265
Financial Transactions and Other	62,817	49,102
	$ 21,049,943	$ 20,417,330

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Schedules to the Consolidated Financial Statements

Year Ended March 31, 2017

Schedule 3
Consolidated Related Party Transactions
(in thousands)

Related parties are those entities consolidated or accounted for on a modified equity basis in the Province of Alberta's consolidated financial statements. Related parties also include key management personnel in the Ministry.

The Ministry and its employees paid or collected certain taxes and fees set by regulation for permits, licenses and other charges. These amounts were incurred in the normal course of business, reflect charges applicable to all users, and have been excluded from this Schedule.

The Ministry had the following transactions with related parties recorded in the Consolidated Statement of Operations and the Consolidated Statement of Financial Position at the amount of consideration agreed upon between the related parties.

	2017	2016 (Restated - Note 3)
Revenues		
Government of Alberta Transfers		
- Transfer from funds	$ 22,174	$ 23,000
- Alberta Infrastructure	348,885	311,432
- Other Ministries	23,086	66,345
Other	91,506	39,591
	$ 485,651	$ 440,368
Expenses - Directly Incurred		
Grants	$ 115,919	$ 113,305
Other	149,625	148,340
Interest	14,900	14,351
	$ 280,444	$ 275,996
Receivables	$ 65,903	$ 66,128
Payables/Deferred Revenue		
- Alberta Infrastructure	$ 6,132,914	$ 6,079,989
- Other Ministries	72,695	34,052
	$ 6,205,609	$ 6,114,041
Debt	$ 320,087	$ 326,909
Contractual Obligations	$ 70,577	$ 20,419

The Ministry receives services under contracts managed by Service Alberta. Any commitments under these contracts are reported by Service Alberta.

The Ministry also had transactions with related parties for which no consideration was exchanged. The amounts for these related party transactions are estimated based on the costs incurred by the service provider to provide the service. These amounts are not reported in the consolidated financial statements and are disclosed in Schedule 4.

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Schedules to the Consolidated Financial Statements

Year Ended March 31, 2017

Schedule 4

Consolidated Allocated Costs

(in thousands)

Program	2017 Expenses [1]	2017 Expenses - Incurred by Others: Accommodation Costs [2]	2017 Expenses - Incurred by Others: Legal Services	2017 Expenses - Incurred by Others: Business Services [3]	2017 Total	2016 (Restated - Note 3) Total
Ministry Support Services	$ 66,688	$ 37,004	$ 4,885	$ 8,689	$ 117,266	$ 113,314
Physician Compensation and Development	5,081,857	-	-	-	5,081,857	4,856,963
Drugs and Supplemental Health Benefits	2,109,530	-	-	-	2,109,530	1,993,992
Community Programs and Healthy Living	453,187	-	-	-	453,187	440,649
Facility-based Patient Services	5,483,736	-	-	-	5,483,736	5,443,094
Care-based Services	1,929,025	-	-	-	1,929,025	1,840,482
Diagnostic,Therapeutic & Other Patient Services	2,388,461	-	-	-	2,388,461	2,325,363
Administration and Support Services	2,586,723	-	-	-	2,586,723	2,478,595
Information Systems	577,948	-	-	-	577,948	637,612
Support Programs	190,399	-	-	-	190,399	172,287
Research and Education	98,630	-	-	-	98,630	94,088
Debt Servicing	16,221	-	-	-	16,221	15,373
Cancer Research and Prevention Investment	8,270	-	-	-	8,270	5,000
Infrastructure Support	59,268	-	-	-	59,268	50,293
	$ 21,049,943	$ 37,004	$ 4,885	$ 8,689	$ 21,100,521	$ 20,467,105

[1] Expenses - Directly Incurred as per Consolidated Statement of Operations.

[2] Accommodation Costs, including grants in lieu of taxes.

[3] Business Services Costs, including charges for IT support, vehicles, internal audit services and other services.

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Schedules to the Consolidated Financial Statements

Year Ended March 31, 2017

Schedule 5
Consolidated Portfolio Investments
(in thousands)

	2017		2016	
	Cost	Fair Value	Cost	Fair Value
Interest bearing securities				
Deposits and short-term securities	$ 207,779	$ 207,779	$ 248,636	$ 248,636
Bonds and mortgages	1,546,500	1,543,462	1,466,168	1,476,511
	1,754,279	1,751,241	1,714,804	1,725,147
Equities:				
Canadian public equities	136,404	157,446	155,830	169,064
Global public equities	312,159	356,179	283,265	293,295
	448,563	513,625	439,095	462,359
Total Portfolio Investments	$ 2,202,842	$ 2,264,866	$ 2,153,899	$ 2,187,506

	2017		2016	
	Cost	Fair Value	Cost	Fair Value
Operating	$ 2,128,132	$ 2,190,156	$ 2,077,933	$ 2,111,540
Endowments	74,710	74,710	75,966	75,966
Total Portfolio Investments	$ 2,202,842	$ 2,264,866	$ 2,153,899	$ 2,187,506

PSAS requires using the following fair value hierarchy for fair value measurements:

- Level 1 – Unadjusted quoted market prices in active markets for identical assets;
- Level 2 – Observable inputs, other than level 1, either directly (i.e. as prices) or indirectly (i.e. derived from prices) for similar assets; and
- Level 3 –Inputs for the assets that are not based on observable market data (unobservable inputs).

Fair Value Hierarchy

	2017				2016			
	Level 1	Level 2	Level 3	Total	Level 1	Level 2	Level 3	Total
Interest bearing securities	$ 106,666	$ 1,507,654	$ 136,921	$1,751,241	$ 108,650	$ 1,491,295	$ 125,202	$1,725,147
Equities	410,475	103,150	-	513,625	361,539	100,820	-	462,359
	$ 517,141	$ 1,610,804	$ 136,921	$2,264,866	$ 470,189	$ 1,592,115	$ 125,202	$2,187,506

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Schedules to the Consolidated Financial Statements

Year Ended March 31, 2017

Schedule 6
List of Entities Included in the Consolidated Financial Statements

Department of Health

Health Quality Council of Alberta

Alberta Health Services

Owns 100 % of the Class A voting shares

Calgary Laboratory Services Ltd.
Capital Care Group Inc.
Carewest

Controlled Foundations

Airdrie Health Foundation
Alberta Cancer Foundation
American Friends of the Calgary Health Trust Foundation
Bassano and District Health Foundation
Bow Island and District Health Foundation
Brooks and District Health Foundation
Calgary Health Trust
Canmore and Area Health Care Foundation
Cardston and District Health Foundation
Claresholm and District Health Foundation
Crowsnest Pass Health Foundation
David Thompson Health Trust *(inactive)*
Fort Macleod and District Health Foundation
Fort Saskatchewan Community Hospital Foundation
Grande Cache Hospital Foundation *(inactive)*
Grimshaw/Berwyn and District Hospital Foundation
Jasper Health Care Foundation
Lac La Biche Regional Health Foundation
Lacombe Health Trust
Medicine Hat and District Health Foundation
Mental Health Foundation
North County Health Foundation
Oyen and District Health Care Foundation
Peace River and District Health Foundation
Ponoka and District Health Foundation
Stettler Health Services Foundation
Strathcona Community Hospital Foundation
Tofield and Area Health Services Foundation
Two Hills Health Centre Foundation
Vermillion and Region Health and Wellness Foundation *(inactive)*
Viking Health Foundation
Vulcan County Health and Wellness Foundation
Windy Slopes Health Foundation

Provincial Health Authorities of Alberta Liability and Property Insurance Plan (LPIP)

AHS has the majority of representation on the LPIP's governance board and is therefore considered to control the LPIP. The main purpose of the LPIP is to share the risks of general and professional liability to lessen the impact on any one subscriber.

Queen Elizabeth II Hospital Child Care Centre

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Schedules to the Consolidated Financial Statements

Year Ended March 31, 2017

Schedule 6 (continued)
List of Entities Included in the Consolidated Financial Statements

Alberta Health Services

Partnerships

AHS uses the proportionate consolidation method to account for its:

- 50% interest in the Primary Care Network (PCN) government partnerships with physician groups.
- 50% interest in the Northern Alberta Clinical Trials Centre partnership with the University of Alberta

The following PCNs are included in these consolidated financial statements on a proportionate basis:

Alberta Heartland Primary Care Network
Aspen (Athabasca/Westlock) Primary Care Network
Big Country Primary Care Network
Bighorn Primary Care Network (previously Grand Cache)
Bonnyville Primary Care Network
Bow Valley Primary Care Network
Calgary Foothills Primary Care Network
Calgary Rural Primary Care Network
Calgary West Central Primary Care Network
Camrose Primary Care Network
Chinook Primary Care Network
Cold Lake Primary Care Network
Drayton Valley Primary Care Network
Edmonton North Primary Care Network
Edmonton Oliver Primary Care Network
Edmonton Southside Primary Care Network
Edmonton West Primary Care Network
Grande Prairie Primary Care Network
Highland Primary Care Network
Kalyna Country Primary Care Network
Lakeland (St. Paul/Aspen) Primary Care Network
Leduc Beaumont Devon Primary Care Network
Lloydminster Primary Care Network
McLeod River Primary Care Network
Mosaic Primary Care Network
Northwest Primary Care Network
Palliser Primary Care Network
Peace Region Primary Care Network
Peaks to Prairies Primary Care Network
Provost Primary Care Network
Red Deer Primary Care Network
Rocky Mountain House Primary Care Network
Sexsmith/Spirit River Primary Care Network
Sherwood Park/ Strathcona County Primary Care Network
South Calgary Primary Care Network
St. Albert & Sturgeon Primary Care Network
Wainwright Primary Care Network
West Peace Primary Care Network
WestView Primary Care Network
Wetaskiwin Primary Care Network
Wolf Creek Primary Care Network
Wood Buffalo Primary Care Network

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FINANCIAL INFORMATION
Department of Health

Financial Statements
March 31, 2017

© 2017 Government of Alberta

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Department of Health

Financial Statements

Year Ended March 31, 2017

© 2017 Government of Alberta

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Financial Statements
March 31, 2017

Auditor's Report

Statement of Operations

Statement of Financial Position

Statement of Change in Net Debt

Statement of Cash Flows

Notes to the Financial Statements

Schedule 1 - Revenues

Schedule 2 - Credit or Recovery

Schedule 3 - Expenses - Directly Incurred Detailed by Object

Schedule 4 - Lapse/Encumbrance

Schedule 5 - Lottery Fund Estimates

Schedule 6 - Salary and Benefits Disclosure

Schedule 7 - Related Party Transactions

Schedule 8 - Allocated Costs

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AUDITOR GENERAL
Alberta

Independent Auditor's Report

To the Minister of Health

Report on the Financial Statements

I have audited the accompanying financial statements of the Department of Health, which comprise the statement of financial position as at March 31, 2017, and the statements of operations, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on these financial statements based on my audit. I conducted my audit in accordance with Canadian generally accepted auditing standards. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

In my opinion, the financial statements present fairly, in all material respects, the financial position of the Department of Health as at March 31, 2017 and the results of its operations, its changes in net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

[Original signed by Merwan N. Saher FCPA, FCA]

Auditor General

June 2, 2017

Edmonton, Alberta

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STATEMENT OF OPERATIONS

Year Ended March 31, 2017
(in thousands)

	2017 Budget	2017 Actual	2016 Actual (Restated - Note 3)
Revenues (Schedule 1)			
Government Transfers			
Government of Alberta Transfers	$ 25,000	$ 22,174	$ 23,000
Federal Government Transfers	4,224,570	4,208,257	4,016,289
Premiums, Fees and Licences	48,001	45,536	46,545
Other Revenue	173,231	276,039	284,220
	4,470,802	4,552,006	4,370,054
Expenses - Directly Incurred (Note 2a(ii) and Schedule 8)			
Programs (Schedules 3 and 4)			
Ministry Support Services	66,899	66,898	63,799
Alberta Health Services	11,859,923	11,909,923	11,457,429
Physician Compensation and Development	4,462,970	4,611,423	4,400,618
Primary Health Care	236,592	172,639	170,722
Addictions and Mental Health	40,399	48,818	39,902
Allied Health Services	102,046	101,369	92,260
Human Tissue and Blood Services	199,521	197,636	192,093
Drugs and Supplemental Health Benefits	1,919,120	1,953,156	1,854,135
Community Programs and Healthy Living	135,904	121,315	111,441
Support Programs	202,327	202,263	183,669
Information Systems	104,123	80,689	76,325
Infrastructure Support	93,527	89,568	79,813
Cancer Research and Prevention Investment	25,000	22,175	23,000
	19,448,351	19,577,872	18,745,206
Annual Deficit	$ (14,977,549)	$ (15,025,866)	$ (14,375,152)

The accompanying notes and schedules are part of these financial statements.

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STATEMENT OF FINANCIAL POSITION

As at March 31, 2017
(in thousands)

	2017	2016 (Restated-Note 3)
Financial Assets		
Cash	$ 1,635	$ 329
Accounts Receivable (Note 4)	146,280	154,873
	147,915	155,202
Liabilities		
Accounts Payable and Accrued Liabilities (Note 5)	543,981	576,811
	543,981	576,811
Net Debt	(396,066)	(421,609)
Non-Financial Assets		
Tangible Capital Assets (Note 6)	65,866	71,904
Inventories of Supplies	15,484	21,810
	81,350	93,714
Net Liabilities	$ (314,716)	$ (327,895)
Net Liabilities, Beginning of Year	$ (327,895)	$ (464,896)
Annual Deficit	(15,025,866)	(14,375,152)
Net Financing Provided from General Revenues	15,039,045	14,512,153
Net Liabilities, End of Year	$ (314,716)	$ (327,895)

Contractual Obligations and Contingent Liabilities (Notes 7 and 8)

The accompanying notes and schedules are part of these financial statements.

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STATEMENT OF CHANGE IN NET DEBT

Year Ended March 31, 2017
(in thousands)

	2017		2016
	Budget	Actual	Actual (Restated - Note 3)
Annual Deficit	$ (14,977,549)	$ (15,025,866)	$ (14,375,152)
Acquisition of Tangible Capital Assets (Note 6)	(22,230)	(12,684)	(11,414)
Amortization of Tangible Capital Assets (Note 6)	18,250	18,722	19,182
Write-offs of Tangible Capital Assets		-	9
Acquistion of Inventories of Supplies	(63,000)	(61,341)	(58,557)
Consumption of Inventories of Supplies	60,700	61,020	59,803
Write-offs of Inventories of Supplies		6,647	1,257
Change in Spent Deferred Capital Contributions		-	(1,440)
Net Financing Provided from General Revenues		15,039,045	14,512,153
Decrease in Net Debt		$ 25,543	$ 145,841
Net Debt, Beginning of Year		(421,609)	(567,450)
Net Debt, End of Year		$ (396,066)	$ (421,609)

The accompanying notes and schedules are part of these financial statements.

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STATEMENT OF CASH FLOWS

Year Ended March 31, 2017
(in thousands)

	2017	2016 (Restated - Note 3)
Operating Transactions		
Annual Deficit	$ (15,025,866)	$ (14,375,152)
Non-cash items included in Annual Deficit:		
Amortization of Tangible Capital Assets (Note 6)	18,722	19,182
Spent Deferred Capital Contributions recognized as Revenue	-	(1,440)
Valuation Adjustments and write-offs	10,221	5,741
	(14,996,923)	(14,351,669)
Decrease (Increase) in Accounts Receivable	5,101	(64,642)
(Decrease) in Accounts Payable and Accrued Liabilities	(32,912)	(85,654)
(Increase) Decrease in Inventories of Supplies	(321)	1,246
Cash (applied to) Operating Transactions	(15,025,055)	(14,500,719)
Capital Transactions		
Acquisition of Tangible Capital Assets (Note 6)	(12,684)	(11,414)
Cash (applied to) Capital Transactions	(12,684)	(11,414)
Financing Transactions		
Net Financing Provided from General Revenues	15,039,045	14,512,153
Cash provided by Financing Transactions	15,039,045	14,512,153
Increase in Cash	1,306	20
Cash, Beginning of Year	329	309
Cash, End of Year	$ 1,635	$ 329

The accompanying notes and schedules are part of these financial statements.

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NOTES TO THE FINANCIAL STATEMENTS
MARCH 31, 2017

Note 1 Authority and Purpose

The Department of Health (the Department) operates under the authority of the *Government Organization Act*, Chapter G-10, Revised Statutes of Alberta 2000.

In support of the Government of Alberta's commitments for a stable and improved public health care system, the Department is to ensure that Albertans receive the right health care services, at the right time, in the right place, provided by the right health care providers and teams.

Note 2 Summary of Significant Accounting Policies and Reporting Practices

These financial statements are prepared in accordance with Canadian Public Sector Accounting Standards.

(a) Basis of Financial Reporting

(i) Revenues

All revenues are reported on the accrual basis of accounting. Cash received for which goods or services have not been provided by year-end is recognized as unearned revenue and included in accounts payable.

Government Transfers

Transfers from other Government of Alberta Departments and federal government are referred to as government transfers.

Government transfers are recognized as deferred capital contributions or deferred revenue if the eligibility criteria of the transfer, or the stipulations, together with the Department's actions and communications as to the use of transfers create a liability. These transfers are recognized as revenues as the stipulations are met and, when applicable, the Department complies with its communicated use of these transfers.

All other government transfers, without terms for the use of the transfer, are recognized as revenue when the transfer is authorized and the Department meets the eligibility criteria (if any).

Credit or Recovery

Credit or recovery initiatives provide a basis for authorizing spending. Credit or recovery is shown in the details of the Government Estimates for a supply vote.

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Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

If budgeted revenues are not fully realized, spending is reduced by an equivalent amount. If actual credit or recovery amounts exceed budget, the Department may, with the approval of the Treasury Board Committee, use the excess revenue to fund additional expenses of the program. Schedule 2 discloses information on the Department's credit or recovery initiatives.

(ii) Expenses

Directly Incurred

Directly incurred expenses are those costs the Department has primary responsibility and accountability for, as reflected in the Government's budget documents.

In addition to program operating expenses such as grants, salaries, supplies etc., directly incurred expenses also include:

- amortization of tangible capital assets;
- consumption of inventories of supplies;
- pension costs, which are the cost of employer contributions for current service of employees during the year; and
- valuation adjustments which include changes in the valuation allowances used to reflect financial assets at their net recoverable or other appropriate value. Valuation adjustments also represent the change in management's estimate of future payments arising from obligations relating to vacation pay.

Grants are recognized as expenses in the period the transfer is authorized and all eligibility criteria have been met by the recipient.

Incurred by Others

Services contributed by other related entities in support of the Department's operations are not recognized and are disclosed in Schedule 8 to show the full cost.

(iii) Valuation of Financial Assets and Liabilities

Fair value is the amount of consideration agreed upon in an arm's length transaction between knowledgeable, willing parties who are under no compulsion to act.

The fair values of cash, accounts receivable, and accounts payable and accrued liabilities are estimated to approximate their carrying values because of the short-term nature of these instruments.

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Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(iv) Financial Assets

Financial assets are assets that could be used to discharge existing liabilities or finance future operations and are not for consumption in the normal course of operations.

Financial assets of the Department are limited to financial claims, such as advances to and receivables from other organizations, employees and other individuals.

Accounts Receivable

Accounts receivable are recognized at the lower of cost or net recoverable value. A valuation allowance is recognized when recovery is uncertain.

(v) Liabilities

Liabilities are present obligations of a government to others arising from past transactions or events, the settlement of which is expected to result in the future sacrifice of economic benefits.

(vi) Non-Financial Assets

Non-financial assets are acquired, constructed or developed assets that do not normally provide resources to discharge existing liabilities, but instead:

(a) are normally employed to deliver government services;
(b) may be consumed in the normal course of operations; and
(c) are not for sale in the normal course of operations.

Non-financial assets of the Department are limited to tangible capital assets and inventories of supplies.

Tangible Capital Assets

Tangible capital assets of the Department are recognized at historical cost and amortized on a straight-line basis over the estimated useful lives of the assets. The threshold for capitalizing new systems development is $250,000 and the threshold for major systems enhancements is $100,000. The threshold for all other tangible capital assets is $5,000.

Amortization is only charged if the tangible capital asset is put into service.

Inventories of Supplies

Inventories consist of vaccines and drugs for distribution at no cost. Inventories of supplies are valued at the lower of cost, determined on a first-in, first-out basis, and replacement cost.

Assets acquired by right are not included.

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Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(vii) Measurement Uncertainty

Measurement uncertainty exists when there is a variance between the recognized or disclosed amount and another reasonably possible amount. Measurement uncertainty that is material to these financial statements exists in the accrual of the Canada Health Transfer.

Canada Health Transfer entitlements are determined on an equal per capita cash basis. Measurement uncertainty for the Canada Health Transfer relates to the population estimate upon which entitlements are based. As the population estimate is finalized, it is used to adjust the entitlements of open prior years. Accordingly, these amounts are estimated and could change by a material amount

(b) Future Accounting Changes

The Public Sector Accounting Board has issued the following accounting standards:

- **PS 2200 Related Party Disclosures and PS 3420 Inter-Entity Transactions (effective April 1, 2017)**
  PS 2200 defines a related party and establishes disclosures required for related party transactions; PS 3420 establishes standards on how to account for and report transactions between public sector entities that comprise a government's reporting entity from both a provider and recipient perspective.

- **PS 3210 Assets, PS 3320 Contingent Assets, and PS 3380 Contractual Rights (effective April 1, 2017)**
  PS 3210 provides guidance for applying the definition of assets set out in FINANCIAL STATEMENT CONCEPTS, Section PS 1000, and establishes general disclosure standards for assets; PS 3320 defines and establishes disclosure standards on contingent assets; PS 3380 defines and establishes disclosure standards on contractual rights.

- **PS 3430 Restructuring Transactions (effective April 1, 2018)**
  This standard provides guidance on how to account for and report restructuring transactions by both transferors and recipients of assets and/or liabilities, together with related program or operating responsibilities.

- **PS 3450 Financial Instruments (effective April 1, 2019)**
  The Department has not yet adopted this standard and has the option of adopting it in fiscal year 2019-20 or earlier. Adoption of this standard requires corresponding adoption of: PS 2601 Foreign Currency Translation; PS 1201 Financial Statement Presentation; and PS 3041 Portfolio Investments in the same fiscal period. These standards provide guidance on: recognition, measurement and disclosure of financial instruments; standards on how to account for and report transactions that are denominated in a foreign currency; general reporting principles and standards for the disclosure of information in financial statements; and how to account for and report portfolio investments.

  Management is currently assessing the impact of these standards on the financial statements.

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Note 3 Program Transfers

Effective April 1, 2016:

- The responsibility for the operational funding of Alberta Innovates – health solutions was transferred to the Department of Economic Development and Trade.
- The responsibility for the administration of Continuing Care Beds was transferred from the Department of Seniors and Housing.
- The responsibility for funding the Health Workforce Action Plan was transferred from the Department of Labour.

Comparatives for 2016 have been restated as if the Department had always been assigned with its current responsibilities.

Net Liabilities on April 1, 2015 are made up as follows:

Net liabilities as previously reported	$ (443,796)
Transfer to the Department of Economic Development and Trade	-
Transfer from the Department of Seniors and Housing	(21,058)
Transfer from the Department of Labour	(42)
Net liabilities at April 1, 2015	$ (464,896)

Note 4 Accounts Receivable
(in thousands)

	2017			2016
	Gross Amount	Allowance for Doubtful Accounts	Net Realizable Value	Net Realizable Value
Accounts Receivable	$ 147,120	$ (840)	$ 146,280	$ 154,873

Accounts receivable are unsecured and non-interest bearing.

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Note 5 Accounts Payable and Accrued Liabilities
(in thousands)

	2017	2016 (Restated - Note 3)
Accounts payable and accrued liabilities	$ 524,893	$ 557,095
Unearned revenue	8,991	9,786
Accrued vacation pay	10,097	9,930
	$ 543,981	$ 576,811

Note 6 Tangible Capital Assets
(in thousands)

	2017			2016
	Equipment [1]	Computer Hardware and Software	Total	Total
Estimated Useful Life	10 years	3 - 10 years		
Historical Cost [2]				
Beginning of year	$ 2,394	$ 230,070	$ 232,464	$ 221,448
Additions	55	12,629	12,684	11,414
Disposals, including write-downs	-	-	-	(398)
	2,449	242,699	245,148	232,464
Accumulated Amortization				
Beginning of year	2,094	158,466	160,560	141,767
Amortization expense	75	18,647	18,722	19,182
Effect of disposals	-	-	-	(389)
	2,169	177,113	179,282	160,560
Net Book Value at March 31, 2017	$ 280	$ 65,586	$ 65,866	
Net Book Value at March 31, 2016	$ 300	$ 71,604		$ 71,904

(1) Equipment includes office equipment and furniture.

(2) Historical cost includes work-in-progress at March 31, 2017 for computer hardware and software totaling $10,648 ($8,377).

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Note 7 Contractual Obligations
(in thousands)

Contractual obligations are obligations of the Department to others that will become liabilities in the future when the terms of those contracts or agreements are met. As at March 31, 2017, the Department has the following contractual obligations:

	2017	2016 (Restated - Note 3)
Specific Program Commitments	$ 567,593	$ 401,002
Capital Contracts	2,166	6,147
Service Contracts	141,249	165,214
	$ 711,008	$ 572,363

Estimated payment requirements for each of the next five years and thereafter are as follows:

	Specific Program Commitments	Capital Contracts	Service Contracts	Total
2017-18	$ 465,484	$ 2,166	$ 66,722	$ 534,372
2018-19	101,157	-	36,286	137,443
2019-20	821	-	33,060	33,881
2020-21	131	-	3,430	3,561
2021-22	-	-	1,751	1,751
Thereafter	-	-	-	-
	$ 567,593	$ 2,166	$ 141,249	$ 711,008

Canadian Blood Services

The Government of Alberta is committed to provide funding to Canadian Blood Services (CBS) for the provision of blood services in Alberta. This commitment was outlined in a Memorandum of Understanding, signed in January 1998, which recorded the understandings and commitments of the Minister of Health of Canada and the Provincial and Territorial Ministers of Health (except Quebec) regarding their respective roles and responsibilities in a renewed national blood system.

Alberta's obligation for the operational costs of CBS is determined on a per capita basis, and the costs for fractionated blood and blood products is determined on the basis of annual utilization of these products. During the year, payments to CBS amounted to $196,000 ($191,000).

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Note 8 Contingent Liabilities and Equity Agreements
(in dollars)

Equity Agreements with Voluntary Hospital Owners

The Department has a contingent liability for buy-out of equity under Equity Agreements entered into between the Department and Voluntary Hospital Owners. The Department's payout liability is contingent upon notification by the voluntary hospital owner of termination of the equity agreement. At March 31, 2017, the contingent payout liability upon termination is estimated at $12.8 million (2016 - $12.8 million).

Other Contingent Liabilities

The Department has been named in nine claims (2016 – fourteen claims), the outcome of which is not determinable. Of these claims, five have specified amounts totaling $89.6 million (2016 – ten claims with a specified amount of $101.5 million). Included in the total claims, three claims totaling $88.9 million (2016 – nine claims totaling $100.9 million) are covered in whole or in part by the Alberta Risk Management Fund. The resolution of indeterminable claims may result in a liability, if any, that may be significantly lower than the claimed amount.

The Department has been named as a co-defendant, along with AHS, in a certified Class Action (the claim) arising from increases to long-term accommodation charges, implemented by Alberta Government regulations enacted on and after August 1, 2003, and paid by residents of long-term care facilities. The amount of the claim has not yet been specified.

Indemnity

As described in Note 7, CBS provides blood services in Alberta. CBS has established two wholly-owned captive insurance corporations, CBS Insurance Company Limited (CBSI) and Canadian Blood Services Captive Insurance Company Limited (CBSE). CBSI provides insurance coverage up to $250 million with respect to risks associated with the operation of the blood system.

CBSE was capitalized in whole through funding from the provinces and territories (except Quebec), through a Captive Support Agreement dated September 28, 2006 ("CSA"), between the provinces, territories, and CBSE. Under the CSA, each of the provinces and territories provided their Pro Rata Share (as defined in the CSA) through an indemnity. Alberta's Pro Rata Share is 13.1% of CBSE's total capital amount, which amounts to $98.0 million. Authority for Alberta to provide the indemnity under the CSA is pursuant to section 5.05 of the Indemnity Authorization Regulation 22/1997, under the *Financial Administration Act*.

The expense recognition criterion for the indemnity is notification from CBS that the indemnity is required. At March 31, 2017, no amount has been recognized for this indemnity.

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Note 9 Payments under Reciprocal and Other Agreements
(in thousands)

The Department entered into agreements, under the Alberta Health Care Insurance Plan, with other Provincial and Territorial Governments to provide health services on their behalf. The Department pays service providers for services rendered under the agreements and recovers the amount paid from the program sponsors. Service providers include Alberta Health Services and physicians. Costs under these agreements are incurred by the Department under authority in section 25 of the *Financial Administration Act*.

In addition, Alberta undertook the role as lead province for the Health Support Committee effective October 19, 2016 to October 19, 2017. The primary focus of the role is to provide secretariat functions for the activities and initiatives.

Accounts receivable includes $46,508 (2016 - $31,673) and accounts payable includes $216 (2016 - $0).

Amounts paid under agreements with program sponsors are as follows:

	2017	2016
Other Provincial and Territorial Governments	$ 298,807	$ 308,559
Health Support Committee	216	-
	$ 299,023	$ 308,559

Note 10 Benefit Plans
(in thousands)

The Department participates in the multi-employer pension plans: Management Employees Pension Plan, Public Service Pension Plan and Supplementary Retirement Plan for Public Service Managers. The expense for these pension plans is equivalent to the annual contributions of $12,962 for the year ended March 31, 2017 (2016 - Restated $12,990). The Department is not responsible for future funding of the plan deficit other than through contribution increases.

At December 31, 2016, the Management Employees Pension Plan reported a surplus of $402,033 (2015 - $299,051), the Public Service Pension Plan reported a surplus of $302,975 (2015 - deficiency $133,188) and the Supplementary Retirement Plan for Public Service Managers reported a deficiency of $50,020 (2015 - $16,305).

The Department also participates in two multi-employer Long Term Disability Income Continuance Plans. At March 31, 2017, the Bargaining Unit Plan reported an actuarial surplus of $101,515 (2016 - $83,066) and the Management, Opted Out and Excluded Plan reported an actuarial surplus of $31,439 (2016 - $29,246). The expense for these two plans is limited to the employer's annual contributions for the year.

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Note 11 Comparative Figures

Certain 2016 figures have been reclassified to conform to the 2017 presentation.

Note 12 Approval of Financial Statements

The deputy minister and the senior financial officer approve these financial statements.

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Schedule to Financial Statements

Year Ended March 31, 2017

SCHEDULE 1

Revenues

(in thousands)

	2017		2016
	Budget	Actual	Actual (Restated - Note 3)
Government of Alberta Transfers			
Alberta Cancer Prevention Legacy Fund	$ 25,000	$ 22,174	$ 23,000
Federal Government Transfers			
Canada Health Transfer	4,223,370	4,200,830	4,013,942
Other	1,200	7,427	2,347
	4,224,570	4,208,257	4,016,289
Premiums, Fees and Licences			
Supplementary Health Benefit Premiums	48,000	45,534	46,543
Miscellaneous	1	2	2
	48,001	45,536	46,545
Other Revenue			
Third Party Recoveries	109,540	150,515	129,056
Product Listing Agreements	50,000	110,667	107,911
Previous years' refunds of expenditure	4,000	14,010	36,254
Miscellaneous	9,691	847	10,999
	173,231	276,039	284,220
	$ 4,470,802	$ 4,552,006	$ 4,370,054

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Schedule to Financial Statements
Year Ended March 31, 2017

SCHEDULE 2
Credit or Recovery
(in thousands)

	2017				
	Authorized	Actual Revenue Recognized	Deferred Revenue	Actual Revenue Received / Receivable	(Shortfall) / Excess
Support Programs					
Other Support Programs [a]	$ 1,000	$ -	$ -	$ -	$ (1,000)
	$ 1,000	$ -	$ -	$ -	$ (1,000)

[a] The Department receives funding from Health Canada to enhance existing health services to persons with chronic Hepatitis C virus infection.

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Schedule to Financial Statements

Year Ended March 31, 2017

SCHEDULE 3

Expenses - Directly Incurred Detailed by Object

(in thousands)

	2017		2016
	Budget	Actual	Actual (Restated - Note 3)
Grants	$ 19,130,790	$ 19,278,775	$ 18,453,704
Supplies and Services	123,568	106,384	105,555
Salaries, Wages and Employee Benefits	112,933	102,765	101,068
Amortization of Tangible Capital Assets	18,250	18,722	19,182
Consumption of Inventories of Supplies	60,700	61,020	59,803
Other	2,110	10,206	5,894
	$ 19,448,351	$ 19,577,872	$ 18,745,206

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Schedule to Financial Statements

Year Ended March 31, 2017

SCHEDULE 4

Lapse/Encumbrance
(in thousands)

Program - Operating Expense	Voted Estimate [1]	Supplementary Estimate [2]	Adjustments [3]	Adjusted Voted Estimate	Voted Actuals [4]	Unexpended / (Over Expended)
1 Ministry Support Services						
1.1 Minister's Office	$ 745	$ -	$ -	$ 745	$ 733	$ 12
1.2 Associate Minister's Office	365	-	-	365	343	22
1.3 Deputy Minister's Office	1,126	-	-	1,126	1,110	16
1.4 Communications	3,366	-	-	3,366	4,370	(1,004)
1.5 Strategic Corporate Support	47,157	-	-	47,157	44,390	2,767
1.6 Policy Development and Strategic Support	11,997	4,000	-	15,997	14,311	1,686
1.7 Health Advocates' Office	1,893	-	-	1,893	1,484	409
	66,649	4,000	-	70,649	66,741	3,908
2 Alberta Health Services						
2.1 Continuing and Community Care	2,037,488	-	-	2,037,488	2,037,488	-
2.2 Home Care	592,104	-	-	592,104	592,104	-
2.3 Acute Care	3,867,891	-	-	3,867,891	3,917,891	(50,000)
2.4 Ambulance Services	401,808	-	-	401,808	401,808	-
2.5 Diagnostic and Therapeutic Services	2,233,106	-	-	2,233,106	2,233,106	-
2.6 Population and Public Health	346,600	-	-	346,600	346,600	-
2.7 Research and Education	33,157	-	-	33,157	33,157	-
2.8 Information Technology	453,965	-	-	453,965	453,965	-
2.9 Support Services	1,460,520	-	-	1,460,520	1,460,520	-
2.10 Administration	433,284	-	-	433,284	433,284	-
	11,859,923	-	-	11,859,923	11,909,923	(50,000)

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Schedule to Financial Statements

Year Ended March 31, 2017

SCHEDULE 4 (Cont'd)

Lapse/Encumbrance

(in thousands)

Program - Operating Expense	Voted Estimate [1]	Supplementary Estimate [2]	Adjustments [3]	Adjusted Voted Estimate	Voted Actuals [4]	Unexpended / (Over Expended)
3 Physician Compensation and Development						
3.1 Program Support	$ 9,702	$ (2,000)	$ -	$ 7,702	$ 7,624	$ 78
3.2 Primary Care Physician Remuneration	1,430,825	54,000	-	1,484,825	1,479,859	4,966
3.3 Specialist Physician Remuneration	2,425,326	210,000	-	2,635,326	2,597,417	37,909
3.4 Physician Development	179,186	(4,000)	-	175,186	175,819	(633)
3.5 Physician Benefits	417,931	(58,000)	-	359,931	347,751	12,180
	4,462,970	200,000	-	4,662,970	4,608,470	54,500
4 Primary Health Care						
4.1 Program Support	3,587	-	-	3,587	2,807	780
4.2 Primary Health Care	233,005	(60,000)	-	173,005	169,832	3,173
	236,592	(60,000)	-	176,592	172,639	3,953
5 Addictions and Mental Health						
5.1 Program Support	3,039	-	-	3,039	2,489	550
5.2 Addictions and Mental Health	37,360	-	-	37,360	44,184	(6,824)
	40,399	-	-	40,399	46,673	(6,274)
6 Allied Health Services	102,046	-	-	102,046	101,369	677
7 Human Tissue and Blood Services	199,521	-	-	199,521	197,636	1,885

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Schedule to Financial Statements

Year Ended March 31, 2017

SCHEDULE 4 (Cont'd)

Lapse/Encumbrance

(in thousands)

Program - Operating Expense	Voted Estimate [1]	Supplementary Estimate [2]	Adjustments [3]	Adjusted Voted Estimate	Voted Actuals [4]	Unexpended / (Over Expended)
8 Drugs and Supplemental Health Benefits						
8.1 Program Support	$ 36,106	$ 3,000	$ -	$ 39,106	$ 39,847	$ (741)
8.2 Outpatient Cancer Therapy Drugs	180,561	5,000	-	185,561	186,000	(439)
8.3 Outpatient Specialized High Cost Drugs	140,371	(37,000)	-	103,371	102,509	862
8.4 Seniors Drug Benefits	548,374	19,000	-	567,374	562,283	5,091
8.5 Seniors Dental, Optical and Supplemental Health Benefits	123,661	(2,000)	-	121,661	119,388	2,273
8.6 Non-Group Drug Benefits	222,276	57,301	(30,301)	249,276	242,915	6,361
8.7 Non-Group Supplemental Health Benefits	850	-	-	850	828	22
8.8 Assured Income for the Severely Handicapped Health Benefit	256,874	(17,000)	-	239,874	238,802	1,072
8.9 Child Health Benefit	28,234	2,000	-	30,234	29,654	580
8.10 Adult Health Benefit	178,259	32,000	-	210,259	210,008	251
8.11 Alberta Aids to Daily Living	142,000	3,000	-	145,000	145,155	(155)
8.12 Pharmaceutical Innovation and Management	54,054	15,000	-	69,054	69,367	(313)
	1,911,620	80,301	(30,301)	1,961,620	1,946,756	14,864
9 Community Programs and Healthy Living						
9.1 Program Support	18,909	(7,000)	-	11,909	11,360	549
9.2 Immunization Support	7,738	(3,000)	-	4,738	4,976	(238)
9.3 Community-Based Health Services	56,057	(13,000)	-	43,057	43,297	(240)
	82,704	(23,000)	-	59,704	59,633	71

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Schedule to Financial Statements

Year Ended March 31, 2017

SCHEDULE 4 (Cont'd)

Lapse/Encumbrance

(in thousands)

Program - Operating Expense	Voted Estimate [1]	Supplementary Estimate [2]	Adjustments [3]	Adjusted Voted Estimate	Voted Actuals [4]	Unexpended (Over Expended)
10 Support Programs						
10.1 Program Support	$ 19,412	$ (2,334)	$ -	$ 17,078	$ 16,455	$ 623
10.2 Out-of-Province Health Care Services	141,461	9,000	-	150,461	153,653	(3,192)
10.3 Health Quality Council of Alberta	6,611	334	-	6,945	6,946	(1)
10.4 Protection for Persons in Care	2,316	-	-	2,316	1,559	757
10.5 Monitoring, Investigations and Licensing	7,817	(1,000)	-	6,817	7,068	(251)
10.6 Other Support Programs	19,710	(5,000)	-	14,710	14,811	(101)
10.7 Health System Projects	3,000	(1,000)	-	2,000	1,759	241
	200,327	-	-	200,327	202,251	(1,924)
11 Information Systems						
11.1 Program Support	7,378	-	-	7,378	6,734	644
11.2 Development and Operations	78,745	(17,000)	-	61,745	55,308	6,437
	86,123	(17,000)	-	69,123	62,042	7,081
12 Cancer Research and Prevention Investment	25,000	(1,695)	-	23,305	22,174	1,131
Program - Capital Grants						
14 Infrastructure Support						
14.1 Continuing Care Beds	43,000	19,454	-	62,454	59,268	3,186
Credit or Recovery (Shortfall) (Schedule 2)	-	-	(1,000)	(1,000)	-	(1,000)
Total	$ 19,316,874	$ 202,060	$ (31,301)	$ 19,487,633	$ 19,455,575	$ 32,058
Lapse/(Encumbrance)						$ 32,058

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Schedule to Financial Statements

Year Ended March 31, 2017

SCHEDULE 4 (Cont'd)

Lapse/Encumbrance

(in thousands)

Program - Capital Investment	Voted Estimate [1]	Supplementary Estimate [2]	Adjustments [3]	Adjusted Voted Estimate	Voted Actuals [4]	Unexpended / (Over Expended)
1 Ministry Support Services						
1.5 Strategic Corporate Support	$ -	$ -	$ -	$ -	$ 10	$ (10)
5 Addictions and Mental Health						
5.2 Addictions and Mental Health	-	-	-	-	2,146	(2,146)
9 Community Programs and Healthy Living						
9.2 Immunization Support	-	-	-	-	45	(45)
11 Information Systems						
11.2 Development and Operations	22,230	-	-	22,230	12,629	9,601
14 Infrastructure Support						
14.3 External Information Systems Development	14,748	-	-	14,748	3,800	10,948
14.4 Equipment for Cancer Corridor Projects	10,779		-	10,779	-	10,779
14.5 Medical Equipment Replacement and Upgrade Program	25,000	-	-	25,000	25,000	-
14.6 Climate Leadership Plan - Green Infrastructure	-	1,500	-	1,500	1,500	-
Total	$ 72,757	$ 1,500	$ -	$ 74,257	$ 45,130	$ 29,127
Lapse/(Encumbrance)						$ 29,127

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Schedule to Financial Statements

Year Ended March 31, 2017

SCHEDULE 4 (Cont'd)

Lapse/Encumbrance

(in thousands)

	Voted Estimate [1]	Supplementary Estimate [2]	Adjustments [3]	Adjusted Voted Estimate	Voted Actuals [4]	Unexpended (Over Expended)
Program - Financial						
8 Drugs and Supplemental Health Benefits						
8.3 Outpatient Specialized High Cost Drugs	$ 7,500	$ -	$ -	$ 7,500	$ 5,872	$ 1,628
9 Community Programs and Healthy Living						
9.2 Immunization Support	55,500	-	-	55,500	55,469	31
Total	$ 63,000	$ -	$ -	$ 63,000	$ 61,341	$ 1,659
Lapse/(Encumbrance)						$ 1,659

[1] As per "Expense Vote by Program", "Capital Investment Vote by Program" and "Financial Transactions Vote by Program" page 128 to 130 of 2016-2017 Government Estimates.

[2] Per the Supplementary Estimates approved on March 7, 2017.

[3] Adjustments include encumbrances, capital carryforward amounts and credit or recovery increases approved by Treasury Board Committee and credit or recovery shortfalls. An encumbrance is incurred when, on a vote by vote basis, the total of actual disbursements in the prior year exceed the total adjusted estimate. All calculated encumbrances from the prior year are reflected as an adjustment to reduce the corresponding voted estimate in the current year.

[4] Actuals exclude non-voted amounts such as amortization, inventory consumption, and valuation adjustments.

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Schedule to Financial Statements

Year Ended March 31, 2017

SCHEDULE 5

Lottery Fund Estimates

(in thousands)

	Lottery Fund Estimates	Actual	Unexpended (Over Expended)
Alberta Health Services			
- Community and Population Health Services	$ 664,943	$ 664,943	$ -
	$ 664,943	$ 664,943	$ -

This table shows details of the initiatives within the department that are funded by the Lottery Fund and compares it to the actual results.

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Schedule to Financial Statements

Year Ended March 31, 2017

SCHEDULE 6

Salary and Benefits Disclosure

(in dollars)

	2017				2016
	Base Salary [1]	Other Cash Benefits [2]	Other Non-cash Benefits [3]	Total	Total
Deputy Minister [4]	$ 327,800	$ 7,969	$ 67,144	$ 402,913	$ 498,083
Associate Deputy Minister [5]	16,493	-	4,183	20,676	-
Executives - Assistant Deputy Ministers					
Financial and Corporate Services [6]	227,346	-	59,854	287,200	282,426
Health Information Systems	184,139	-	48,094	232,233	261,992
Health Standards, Quality and Performance [7]	257,386	-	13,186	270,572	-
Health Services Delivery	184,455	-	46,511	230,966	293,273
Health Workforce Planning and Accountability [8]	183,562	3,949	47,530	235,041	235,376
Innovation and Stakeholder Relations [9]	104,056	-	28,012	132,068	-
Pharmaceutical and Supplementary Benefits [8]	41,640	-	12,459	54,099	-
Public Health and Compliance [10]	168,146	-	42,354	210,500	245,047
Strategic Planning and Policy Development [11]	181,521	116,531	49,417	347,469	272,576

[1] Base salary includes regular salary and earnings such as acting pay.

[2] Other cash benefits include vacation payouts, lump sum payments, and automobile allowance. There were no bonuses paid during the year.

[3] Other non-cash benefits include government's share of all employee benefits and contributions or payments made on behalf of employees including pension, supplementary retirement plan, health care, dental coverage, group life insurance, short and long-term disability plans, professional memberships and tuition fees.

[4] The incumbent is engaged under an arrangement between the University of Alberta (incumbent's employer) and the Department. Salary and benefits to the incumbent are being paid by the University and reimbursed by the Department. The amount paid to the University for the period is $393,360.

[5] The position was created on March 13, 2017.

[6] The position was occupied by two individuals during the year. The occupancy of the position changed March 2017.

[7] The position was created on June 14, 2016 as a result of restructuring. The position was occupied by two individuals during the year. The occupancy of the position changed March 2017.

[8] Professional Services and Health Benefits division was split effective January 3, 2017 and renamed as Health Workforce Planning and Accountability division while creating a separate Pharmaceutical and Supplementary Benefits division.

[9] The position was created on September 19, 2016.

[10] The position was occupied by two individuals during the year. The occupancy of the position changed May 2016.

[11] The position was occupied by two individuals during the year. The occupancy of the position changed January 2017 and effective February 14, 2017 the position was abolished.

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Schedule to Financial Statements

Year Ended March 31, 2017

SCHEDULE 7

Related Party Transactions

(in thousands)

Related parties are those entities consolidated or accounted for on the modified equity basis in the Government of Alberta's financial statements. Related parties also include key management personnel in the department. Entities in the Ministry include AHS and HQCA.

The Department and its employees paid or collected certain taxes and fees set by regulation for permits, licences and other charges. These amounts were incurred in the normal course of business, reflect charges applicable to all users, and have been excluded from this schedule.

The Department had the following transactions with related parties reported on the Statement of Operations and the Statement of Financial Position at the amount of consideration agreed upon between the related parties.

	Entities in the Ministry		Other Entities	
	2017	2016 (Restated - Note 3)	2017	2016 (Restated - Note 3)
Revenues				
Grants	$ -	$ -	$ 22,174	$ 23,000
Other	4,021	3,812	106	508
	$ 4,021	$ 3,812	$ 22,280	$ 23,508
Expenses - Directly Incurred				
Grants[1]	$ 12,913,225	$ 12,332,161	$ 115,919	$ 113,306
Other Services	1,292	1,309	11,287	11,335
	$ 12,914,517	$ 12,333,470	$ 127,206	$ 124,641
Receivable from	$ 171	$ 287	$ 6,337	$ 3
Payable to	$ 64,065	$ 72,515	$ 5,117	$ 2,032
Contractual Obligations	$ 204,785	$ 100,747	$ 66,494	$ 15,394

[1] The grants paid to AHS include amounts that are separately reported on the Statement of Operations.

The Department also had the following transactions with related parties for which no consideration was exchanged. The amounts for these related party transactions are estimated based on the costs incurred by the service provider to provide the service. These amounts are not reported in the financial statements. Expenses are included in Schedule 8.

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Schedule to Financial Statements

Year Ended March 31, 2017

SCHEDULE 8

Allocated Costs

(in thousands)

	2017					2016
		Expenses - Incurred by Others				(Restated - Note 3)
	Expenses [1]	Accommodation Costs [2]	Legal Services	Business Services [3]	Total	Total
Ministry Support Services	$ 66,898	$ 12,636	$ 4,885	$ 8,689	$ 93,108	$ 89,270
Alberta Health Services	11,909,923	-	-	-	11,909,923	11,457,429
Physician Compensation and Development	4,611,423	-	-	-	4,611,423	4,400,618
Primary Health Care	172,639	-	-	-	172,639	170,722
Addictions and Mental Health	48,818	-	-	-	48,818	39,902
Allied Health Services	101,369	-	-	-	101,369	92,260
Human Tissue and Blood Services	197,636	-	-	-	197,636	192,093
Drugs and Supplemental Health Benefits	1,953,156	-	-	-	1,953,156	1,854,135
Community Programs and Healthy Living	121,315	-	-	-	121,315	111,441
Support Programs	202,263	-	-	-	202,263	183,669
Information Systems	80,689	-	-	-	80,689	76,325
Infrastructure Support	89,568	-	-	-	89,568	79,813
Cancer Research and Prevention Investment	22,175	-	-	-	22,175	23,000
	$ 19,577,872	$ 12,636	$ 4,885	$ 8,689	$ 19,604,082	$ 18,770,677

[1] Expenses - Directly Incurred as per Statement of Operations.

[2] Accommodation Costs, including grants in lieu of taxes.

[3] Business Services Costs, including charges for IT support, vehicles, internal audit services and other services.

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FINANCIAL INFORMATION
Alberta Health Services

Consolidated Financial Statements
March 31, 2017

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CONSOLIDATED FINANCIAL STATEMENTS

MARCH 31, 2017

Management's Responsibility for Financial Reporting

Independent Auditor's Report

Consolidated Statement of Operations

Consolidated Statement of Financial Position

Consolidated Statement of Change in Net Debt

Consolidated Statement of Remeasurement Gains and Losses

Consolidated Statement of Cash Flows

Notes to the Consolidated Financial Statements

Schedule 1 – Consolidated Schedule of Expenses by Object

Schedule 2 – Consolidated Schedule of Salaries and Benefits

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MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

The accompanying consolidated financial statements for the year ended March 31, 2017 are the responsibility of management and have been reviewed and approved by senior management. The consolidated financial statements were prepared in accordance with Canadian Public Sector Accounting Standards and the financial directives issued by Alberta Health, and of necessity include some amounts based on estimates and judgment.

To discharge its responsibility for the integrity and objectivity of financial reporting, management maintains systems of financial management and internal control which give consideration to costs, benefits and risks that are designed to:

- provide reasonable assurance that transactions are properly authorized, executed in accordance with prescribed legislation and regulations, and properly recorded so as to maintain accountability of public money;
- safeguard the assets and properties of the "Province of Alberta" under Alberta Health Services' administration

Alberta Health Services carries out its responsibility for the consolidated financial statements through the Audit & Risk Committee (the Committee). The Committee meets with management and the Auditor General of Alberta to review financial matters, and recommends the consolidated financial statements to the Alberta Health Services Board for approval upon finalization of the audit. The Auditor General of Alberta has free access to the Committee.

The Auditor General of Alberta provides an independent audit of the consolidated financial statements. His examination is conducted in accordance with Canadian Generally Accepted Auditing Standards and includes tests and procedures which allow him to report on the fairness of the consolidated financial statements prepared by management.

[Original signed by Dr. Verna Yiu, MD, FRCPC]

Dr. Verna Yiu, MD, FRCPC
President and Chief Executive Officer
Alberta Health Services

[Original signed by Deborah Rhodes, CPA, CA]

Deborah Rhodes, CPA, CA
Vice President Corporate Services and Chief Financial Officer
Alberta Health Services

June 1, 2017

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AUDITOR GENERAL *Alberta*

Independent Auditor's Report

To the Minister of Health

Report on the Consolidated Financial Statements

I have audited the accompanying consolidated financial statements of Alberta Health Services, which comprise the consolidated statement of financial position as at March 31, 2017, and the consolidated statements of operations, remeasurement gains and losses, change in net debt, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on these consolidated financial statements based on my audit. I conducted my audit in accordance with Canadian generally accepted auditing standards. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

In my opinion, the consolidated financial statements present fairly, in all material respects, the financial position of Alberta Health Services as at March 31, 2017, and the results of its operations, its remeasurement gains and losses, its changes in net debt, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

[Original signed by Merwan N. Saher FCPA, FCA]

Auditor General

June 1, 2017

Edmonton, Alberta

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CONSOLIDATED STATEMENT OF OPERATIONS
YEAR ENDED MARCH 31

	2017		2016
	Budget (Note 3)	Actual	Actual
Revenues:			
Alberta Health transfers			
Base operating	$ 11,860,000	$ 11,859,923	$ 11,329,851
One-time base operating	-	50,000	-
Grant funding transferred to one-time base operating	-	14,515	-
Other operating	968,000	953,328	1,064,739
Recognition of expended deferred capital revenue	81,000	86,784	84,716
Other government transfers (Note 4)	405,000	456,152	416,554
Fees and charges	513,000	479,180	491,487
Ancillary operations	133,000	135,660	133,220
Donations, fundraising, and non-government contributions (Note 5)	150,000	164,016	166,806
Investment and other income (Note 6)	205,000	270,410	267,931
TOTAL REVENUE	**14,318,000**	**14,469,968**	**13,955,304**
Expenses:			
Inpatient acute nursing services	3,235,000	3,169,177	3,129,520
Emergency and other outpatient services	1,646,000	1,671,830	1,641,261
Facility-based continuing care services	1,080,000	1,053,118	1,043,410
Ambulance services	479,000	497,686	479,031
Community-based care	1,317,000	1,249,031	1,191,605
Home care	611,000	585,313	555,831
Diagnostic and therapeutic services	2,273,000	2,400,242	2,343,794
Promotion, prevention, and protection services	393,000	354,700	353,028
Research and education	240,000	285,300	277,908
Administration (Note 7)	458,000	478,074	434,426
Information technology	572,000	513,420	572,545
Support services (Note 8)	2,014,000	2,145,541	2,077,504
TOTAL EXPENSES (Schedule 1)	**14,318,000**	**14,403,432**	**14,099,863**
ANNUAL OPERATING SURPLUS (DEFICIT)	**-**	**66,536**	**(144,559)**
Accumulated surplus, beginning of year	1,159,000	1,159,123	1,303,682
Accumulated surplus, end of year (Note 19)	**$ 1,159,000**	**$ 1,225,659**	**$ 1,159,123**

The accompanying notes and schedules are part of these consolidated financial statements.

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CONSOLIDATED STATEMENT OF FINANCIAL POSITION
AS AT MARCH 31

	2017 Actual	2016 Actual
Financial Assets:		
Cash	$ 46,103	$ 79,867
Investments (Note 10)	2,264,866	2,187,506
Accounts receivable (Note 11)	386,292	393,493
	2,697,261	2,660,866
Liabilities:		
Accounts payable and accrued liabilities (Note 12)	1,209,974	1,236,312
Employee future benefits (Note 13)	653,037	620,687
Unexpended deferred operating revenue (Note 14)	411,079	429,515
Unexpended deferred capital revenue (Note 15)	137,806	148,319
Debt (Note 17)	320,087	326,909
	2,731,983	2,761,742
NET DEBT	**(34,722)**	**(100,876)**
Non-Financial Assets:		
Tangible capital assets (Note 18)	7,619,077	7,573,071
Inventories for consumption	91,882	94,439
Prepaid expenses and other non-financial assets	128,058	127,943
	7,839,017	7,795,453
NET ASSETS BEFORE EXPENDED DEFERRED CAPITAL REVENUE	7,804,295	7,694,577
Expended deferred capital revenue (Note 16)	6,549,770	6,530,432
NET ASSETS	**1,254,525**	**1,164,145**
Net Assets is comprised of:		
Accumulated surplus (Note 19)	1,225,659	1,159,123
Accumulated remeasurement gains	28,866	5,022
	$ 1,254,525	**$ 1,164,145**

Contractual Obligations and Contingent Liabilities (Note 20)

The accompanying notes and schedules are part of these consolidated financial statements.

Approved by the Board of Directors:

[Original signed by Linda Hughes]

Linda Hughes
Board Chair

[Original signed by David Carpenter, FCPA, FCA]

David Carpenter, FCPA, FCA
Audit & Risk Committee Chair

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CONSOLIDATED STATEMENT OF CHANGE IN NET DEBT
YEAR ENDED MARCH 31

	2017		2016
	Budget (Note 3)	Actual	Actual
Annual operating surplus (deficit)	$ -	$ 66,536	$ (144,559)
Effect of changes in tangible capital assets:			
Acquisition of tangible capital assets (Note 18)	(402,000)	(597,021)	(650,785)
Amortization and disposals of tangible capital assets (Note 18)	587,000	551,015	588,851
Effect of other changes:			
Net increase (decrease) in expended deferred capital revenue	(217,000)	19,338	166,733
Net (increase) decrease in inventories for consumption	1,000	2,557	2,144
Net (increase) decrease in prepaid expenses and other non-financial assets	(5,000)	(115)	10,846
Net remeasurement gains (losses) for the year	(19,000)	23,844	(33,753)
(Increase) decrease in net debt for the year	**(55,000)**	**66,154**	**(60,523)**
Net debt, beginning of year	(101,000)	(100,876)	(40,353)
Net debt, end of year	**$ (156,000)**	**$ (34,722)**	**$ (100,876)**

The accompanying notes and schedules are part of these consolidated financial statements.

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CONSOLIDATED STATEMENT OF REMEASUREMENT GAINS AND LOSSES
YEAR ENDED MARCH 31

	2017 Actual	2016 Actual
Unrestricted unrealized gains (losses) attributable to:		
Derivatives	$ 643	$ (2,451)
Portfolio investments		
Equity instruments quoted in an active market	14,456	(12,894)
Financial instruments designated to the fair value category	(786)	(3,360)
Amounts reclassified to the Consolidated Statement of Operations:		
Portfolio investments		
Equity instruments quoted in an active market	559	783
Financial instruments designated to the fair value category	8,976	(15,831)
Net remeasurement gains (losses) for the year	**23,844**	**(33,753)**
Accumulated remeasurement gains, beginning of year	5,022	38,775
Accumulated remeasurement gains, end of year (Note 10)	**$ 28,866**	**$ 5,022**

The accompanying notes and schedules are part of these consolidated financial statements.

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CONSOLIDATED STATEMENT OF CASH FLOWS
YEAR ENDED MARCH 31

	2017 Actual	2016 Actual
Operating transactions:		
Annual operating surplus (deficit)	$ 66,536	$ (144,559)
Non-cash items:		
Amortization and disposals of tangible capital assets	551,015	588,851
Recognition of expended deferred capital revenue	(402,887)	(394,294)
Revenue recognized for acquisition of land	(687)	-
Decrease (increase) in:		
Accounts receivable related to operating transactions	(26,890)	(49,250)
Inventories for consumption	2,557	2,144
Prepaid expenses and other non-financial assets	(115)	10,846
Increase (decrease) in:		
Accounts payable and accrued liabilities related to operating transactions	(51,771)	(39,564)
Employee future benefits	32,350	26,084
Unexpended deferred operating revenue	(70,148)	(80,367)
Cash provided by (applied to) operating transactions	99,960	(80,109)
Capital transactions:		
Acquisition of tangible capital assets	(380,401)	(233,213)
Increase (decrease) in accounts payable and accrued liabilities related to capital transactions	25,433	(6,434)
Cash applied to capital transactions	(354,968)	(239,647)
Investing transactions:		
Purchase of investments	(3,339,338)	(4,230,911)
Proceeds on disposals of investments	3,290,394	4,133,948
Cash applied to investing transactions	(48,944)	(96,963)
Financing transactions:		
Restricted capital contributions received	278,230	164,359
Unexpended deferred capital revenue returned	(1,220)	(4,698)
Proceeds from debt	10,000	20,300
Principal payments on debt	(16,822)	(15,222)
Cash provided by financing transactions	270,188	164,739
Decrease in cash	**(33,764)**	**(251,980)**
Cash, beginning of year	79,867	331,847
Cash, end of year	**$ 46,103**	**$ 79,867**

The accompanying notes and schedules are part of these consolidated financial statements.

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NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
MARCH 31, 2017

Note 1 Authority, Purpose and Operations

Alberta Health Services (AHS) was established under the *Regional Health Authorities Act* (Alberta), effective April 1, 2009, as a result of the merger of 12 formerly separate health entities in Alberta.

Pursuant to Section 5 of the *Regional Health Authorities Act* (Alberta), AHS is responsible in Alberta to:

- promote and protect the health of the population in the health region and work toward the prevention of disease and injury;
- assess on an ongoing basis the health needs of the health region;
- determine priorities in the provision of health services in the health region and allocate resources accordingly;
- ensure that reasonable access to quality health services is provided in and through the health region; and
- promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in the health region.

Additionally, AHS is accountable to the Minister of Health (the Minister) for the delivery and operation of the public health system.

The AHS consolidated financial statements include the revenue and expenses associated with its responsibilities. These consolidated financial statements do not reflect the complete costs of provincial health care. For a complete picture of the costs of provincial health care, readers should consult the consolidated financial statements of the Government of Alberta (GOA).

AHS and its contracted health service providers deliver health services at facilities and sites grouped in the following areas: addiction treatment, community mental health, standalone psychiatric facilities, acute care hospitals, sub-acute care in auxiliary hospitals, long-term care, palliative care, supportive living, cancer care, community ambulatory care centres, and urgent care centres.

Under the *Income Tax Act (Canada)*, AHS is a registered charity.

Note 2 Significant Accounting Policies and Reporting Practices

(a) Basis of Presentation

These consolidated financial statements have been prepared in accordance with Canadian Public Sector Accounting Standards (PSAS) and the financial directives issued by Alberta Health (AH). AHS is a Government Not-for-Profit Organization under PSAS.

These financial statements have been prepared on a consolidated basis and include the following entities:

(i) Controlled Entities

The consolidated financial statements reflect the assets, liabilities, revenues, and expenses of the reporting entity, which is comprised of the organizations controlled by AHS as noted below:

AHS owns 100% of the Class A voting shares in the following three entities:

- Calgary Laboratory Services Ltd. (CLS) - provides medical diagnostic services in Calgary and southern Alberta.
- Capital Care Group Inc. (CCGI) - manages continuing care programs and facilities in the Edmonton area.
- Carewest - manages continuing care programs and facilities in the Calgary area.

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Note 2 Significant Accounting Policies and Reporting Practices (continued)

AHS has the majority representation indicating control of the following entities and therefore constitute part of the consolidated reporting entity:

- Foundations:

Airdrie Health Foundation
Alberta Cancer Foundation (ACF)
American Friends of the Calgary Health Trust Foundation
Bassano and District Health Foundation
Bow Island and District Health Foundation
Brooks and District Health Foundation
Calgary Health Trust (CHT)
Canmore and Area Health Care Foundation
Cardston and District Health Foundation
Claresholm and District Health Foundation
Crowsnest Pass Health Foundation
David Thompson Health Trust *(inactive)*
Fort Macleod and District Health Foundation
Fort Saskatchewan Community Hospital Foundation
Grande Cache Hospital Foundation *(inactive)*
Grimshaw/Berwyn and District Hospital Foundation
Jasper Health Care Foundation
Lac La Biche Regional Health Foundation
Lacombe Health Trust
Medicine Hat and District Health Foundation
Mental Health Foundation
North County Health Foundation
Oyen and District Health Care Foundation
Peace River and District Health Foundation
Ponoka and District Health Foundation
Stettler Health Services Foundation
Strathcona Community Hospital Foundation
Tofield and Area Health Services Foundation
Two Hills Health Centre Foundation
Vermillion and Region Health and Wellness Foundation *(inactive)*
Viking Health Foundation
Vulcan County Health and Wellness Foundation
Windy Slopes Health Foundation

- Provincial Health Authorities of Alberta Liability and Property Insurance Plan (LPIP) - AHS has the majority of representation on the LPIP's governance board and is therefore considered to control the LPIP. The main purpose of the LPIP is to share the risks of general and professional liability to lessen the impact on any one subscriber.

- Queen Elizabeth II Hospital Child Care Centre

(ii) Government Partnerships

AHS uses the proportionate consolidation method to account for its 50% interest in the Primary Care Network (PCN) government partnerships with physician groups, and its 50% interest in the Northern Alberta Clinical Trials Centre (NACTRC) partnership with the University of Alberta (Note 22).

AHS has joint control with various physician groups over PCNs. AHS entered into local primary care initiative agreements to jointly manage and operate the delivery of primary care services, to achieve the PCN business plan objectives, and to contract and hold property interests required in the delivery of PCN services.

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Note 2 Significant Accounting Policies and Reporting Practices (continued)

The following PCNs are included in these consolidated financial statements on a proportionate basis:

Alberta Heartland Primary Care Network
Aspen (Athabasca/Westlock) Primary Care Network
Big Country Primary Care Network
Bighorn Primary Care Network (previously Grande Cache)
Bonnyville Primary Care Network
Bow Valley Primary Care Network
Calgary Foothills Primary Care Network
Calgary Rural Primary Care Network
Calgary West Central Primary Care Network
Camrose Primary Care Network
Chinook Primary Care Network
Cold Lake Primary Care Network
Drayton Valley Primary Care Network
Edmonton North Primary Care Network
Edmonton Oliver Primary Care Network
Edmonton Southside Primary Care Network
Edmonton West Primary Care Network
Grande Prairie Primary Care Network
Highland Primary Care Network
Kalyna Country Primary Care Network
Lakeland (St. Paul/Aspen) Primary Care Network
Leduc Beaumont Devon Primary Care Network
Lloydminster Primary Care Network
McLeod River Primary Care Network
Mosaic Primary Care Network
Northwest Primary Care Network
Palliser Primary Care Network
Peace Region Primary Care Network
Peaks to Prairies Primary Care Network
Provost Primary Care Network
Red Deer Primary Care Network
Rocky Mountain House Primary Care Network
Sexsmith/Spirit River Primary Care Network
Sherwood Park/Strathcona County Primary Care Network
South Calgary Primary Care Network
St. Albert & Sturgeon Primary Care Network
Wainwright Primary Care Network
West Peace Primary Care Network
WestView Primary Care Network
Wetaskiwin Primary Care Network
Wolf Creek Primary Care Network
Wood Buffalo Primary Care Network

(iii) Other

These consolidated financial statements do not include trusts administered on behalf of others (Note 23).

All inter-entity accounts and transactions between these organizations are eliminated upon consolidation.

Adjustments are made for consolidated entities whose fiscal year-ends are different from AHS' fiscal year end. This only consists of LPIP with a fiscal year-end of December 31, 2016.

(b) Revenue Recognition

Revenue is recognized in the period in which the transactions or events that give rise to the revenue as described below occur. All revenue is recorded on an accrual basis, except when the accrual cannot be determined within a reasonable degree of certainty or when estimation is impracticable.

(i) Government Transfers

Transfers from AH, other GOA ministries and agencies, and other government entities are referred to as government transfers.

Government transfers and the associated externally restricted investment income are recorded as deferred revenue if the eligibility criteria for the use of the transfer, or the stipulations together with AHS' actions and communications as to the use of the transfer, create a liability. These transfers are recognized as revenue as the stipulations are met and, when applicable, AHS complies with its communicated use of the transfer.

All other government transfers, without stipulations for the use of the transfer, are recorded as revenue when the transfer is authorized and AHS meets the eligibility criteria.

Deferred revenue consists of unexpended deferred operating revenue, unexpended deferred capital revenue, and expended deferred capital revenue. The term deferred revenue in these consolidated financial statements refers to the components of deferred revenue as described.

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Note 2 Significant Accounting Policies and Reporting Practices (continued)

(iii) Donations, Fundraising, and Non-Government Contributions

Donations, fundraising, and non-government contributions are received from individuals, corporations, and other not-for-profit organizations. Donations, fundraising, and non-government contributions may be unrestricted or externally restricted for operating or capital purposes.

Unrestricted donations, fundraising, and non-government contributions are recorded as revenue in the year received or in the year the funds are committed to AHS if the amount can be reasonably estimated and collection is reasonably assured.

Externally restricted donations, fundraising, non-government contributions, and realized and unrealized gains and losses for the associated externally restricted investment income are recorded as deferred revenue if the terms for their use, or the terms along with AHS' actions and communications as to their use create a liability. These resources are recognized as revenue as the terms are met and, when applicable, AHS complies with its communicated use.

Endowment contributions are recognized in the Consolidated Statement of Operations in the period they are received. Donors have placed restrictions on these contributions. Realized and unrealized gains and losses attributable to endowments are recorded as deferred revenue and only recognized as revenue when the terms of use are met, as stipulated by the donors.

In-kind donations of services and materials are recorded at fair value when such value can reasonably be determined. While volunteers contribute a significant amount of time each year to assist AHS, the value of their services is not recognized as revenue and expenses in the consolidated financial statements because fair value cannot be reasonably determined.

(iii) Transfers and Donations of or for Land

AHS records transfers and donations to buy land as a liability when received and recognizes as revenue when AHS buys the land. AHS recognizes in-kind contributions of land as revenue at the fair value of the land when a fair value can be reasonably determined. When AHS cannot determine the fair value, it records such in-kind contributions at nominal value.

(iv) Fees and Charges, Ancillary Operations, and Other Income

Fees and charges, ancillary operations, and other income are recognized in the period that goods are delivered or services are provided. Amounts received for which goods or services have not been provided by year end are recorded as deferred revenue.

(v) Investment Income

Investment income includes dividend income, interest income, and realized gains or losses on the sale of portfolio investments. Unrealized gains and losses on portfolio investments exclusive of restricted transfers or donations are recognized in the Consolidated Statement of Remeasurement Gains and Losses until the related investments are sold. When realized, these gains or losses are recognized in the Consolidated Statement of Operations. Investment income and unrealized gains and losses from restricted transfers or donations are allocated to their respective balances according to the provisions within the individual agreements.

(c) Expenses

Expenses are reported on an accrual basis. The cost of all goods consumed and services received during the year are expensed. Interest expense includes debt servicing costs.

Expenses include grants and transfers under shared cost agreements. Grants and transfers are recorded as expenses when the transfer is authorized and eligibility criteria have been met by the recipient.

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Note 2 Significant Accounting Policies and Reporting Practices (continued)

(d) Financial Instruments

All of AHS' financial assets and liabilities are initially recorded at their fair value. The following table identifies AHS' financial assets and liabilities and identifies how they are subsequently measured:

Financial Assets and Liabilities	Subsequent Measurement and Recognition
Cash and investments	Measured at fair value with changes in fair values recognized in the Consolidated Statement of Remeasurement Gains and Losses or deferred revenue until realized, at which time the cumulative changes in fair value are recognized in the Consolidated Statement of Operations.
Accounts receivable, accounts payable and accrued liabilities and debt	Measured at amortized cost.

PSAS requires portfolio investments in equity instruments quoted in an active market to be recorded under the fair value category and AHS may choose to record other financial assets under the fair value category if there is an investment strategy to evaluate the performance of a group of these financial assets on a fair value basis. AHS has elected to record its money market securities, fixed income securities, and certain other equity investments at fair value. The three levels of information that may be used to measure fair value are:

- Level 1 – Unadjusted quoted market prices in active markets for identical assets or liabilities;
- Level 2 – Observable or corroborated inputs, other than level 1, such as quoted prices for similar assets or liabilities in inactive markets or market data for substantially the full term of the assets or liabilities; and
- Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets and liabilities.

AHS measures and recognizes embedded derivatives separately from the host contract when the economic characteristics and risk of the embedded derivative are not closely related to those of the host contract, when it meets the definition of a derivative and, when the entire contract is not measured at fair value. Embedded derivatives are recorded at fair value. For the year ended March 31, 2017, AHS has no embedded derivatives that require separation from the host contract.

Derivatives are recorded at fair value in the Consolidated Statement of Financial Position. Derivatives with a positive or negative fair value are recognized as increases or decreases to investments. Unrealized gains and losses from changes in the fair value of derivatives are recognized in the Consolidated Statement of Remeasurement Gains and Losses.

All financial assets are assessed for impairment on an annual basis. When a decline is determined to be other than temporary, the amount of the loss is reported as a realized loss on the Consolidated Statement of Operations.

Transaction costs associated with the acquisition and disposal of investments are expensed as incurred. Investment management fees are expensed as incurred. The purchase and sale of investments are accounted for using trade date accounting.

(e) Cash

Cash is comprised of cash on hand.

(f) Inventories For Consumption

Inventories for consumption or distribution at no charge are valued at lower of cost (defined as moving average cost) and replacement cost.

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Note 2 Significant Accounting Policies and Reporting Practices (continued)

(g) Tangible Capital Assets

Tangible capital assets and work in progress are recorded at cost, which includes amounts that are directly related to the acquisition, design, construction, development, improvement, or betterment of the assets. Cost includes overhead directly attributable to construction and development as well as interest costs that are directly attributable to the acquisition or construction of the asset. Contributed tangible capital assets and work in progress acquired from other government organizations and other entities are recorded at their fair value on the date of the transfer. Costs incurred by Alberta Infrastructure (AI) to build tangible capital assets on behalf of AHS are recorded by AHS as work in progress as AI incurs costs.

Works of art, historical treasures, and collections are not recognized in tangible capital assets.

The costs less residual values of tangible capital assets, excluding land, are amortized over their estimated useful lives on a straight-line basis as follows:

	Useful Life
Facilities and improvements	10-40 years
Equipment	3-20 years
Information systems	3-5 years
Building service equipment	5-40 years
Land improvements	5-40 years

Work in progress, which includes facility and improvement projects and development of information systems, is not amortized until after a project is substantially complete and the tangible capital assets are put into service.

Leases transferring substantially all benefits and risks of tangible capital asset ownership are classified as capital leases and reported as tangible capital assets. Capital leases and leasehold improvements are amortized over the term of the lease. The capital lease obligations associated with these capital leases are recorded at the present value of the minimum lease payments excluding executory costs (e.g. insurance, maintenance costs, etc.) and reported as obligations under capital leases. The discount rate used to determine the present value of the lease payments is the lower of AHS' rate for incremental borrowing and the interest rate implicit in the lease.

Tangible capital assets are written down when conditions indicate that they no longer contribute to AHS' ability to provide goods and services or when the value of future economic benefits associated with the tangible capital assets are less than their net book value. The net write-downs are accounted for as expenses in the Consolidated Statement of Operations. Write-downs are not reversed.

(h) Employee Future Benefits

(i) Registered Benefit Pension Plans

AHS participates in the following registered defined benefit pension plans: the Local Authorities Pension Plan (LAPP) and the Management Employees Pension Plan (MEPP). These multi-employer public sector defined benefit plans provide pensions for participants for each year of pensionable service based on the average salary of the highest five consecutive years, up to the average Canada Pension Plan's Year's Maximum Pensionable Earnings (YMPE), over the same five consecutive year period. Benefits for post-1991 service payable under these plans are limited by the *Income Tax Act* (Canada). The President of Alberta Treasury Board and Minister of Finance is the legal trustee and administrator of the plans. The Department of Treasury Board and Finance accounts for its share of obligations for these pension plans relating to former and current employees of all of the organizations included in the GOA consolidated reporting entity on a defined benefit basis. As a participating government organization, AHS accounts for these plans on a defined contribution basis. Accordingly, the pension expense recorded for these plans in these consolidated financial statements is comprised of the employer contributions that AHS is required to pay for its employees during the fiscal year, which are calculated based on actuarially pre-determined amounts that are expected to provide the plan's future benefits.

(ii) Other Defined Contribution Pension Plans

AHS sponsors Group Registered Retirement Savings Plans (GRRSPs) for certain employee groups. Under the GRRSPs, AHS matches a certain percentage of any contribution made by plan participants up to certain limits. AHS also sponsors a defined contribution pension plan for certain employee groups where the employee and employer each contribute specified percentages of pensionable earnings.

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Note 2 Significant Accounting Policies and Reporting Practices (continued)

(iii) Supplemental Retirement Plan for Designated Employees (SERP)

Previously, AHS sponsored multiple SERPs, with assets held in three Retirement Compensation Arrangements (RCA). Since March 31, 2016, amendments were made to consolidate the SERPs into a single plan with assets consolidated under one RCA arrangement. The consolidation did not affect SERP members' accrued benefit entitlements, which continue to be funded. The SERP covers certain employees and supplement the benefits under AHS' registered plans that are limited by the *Income Tax Act* (Canada). Prior to consolidation, the SERPs were closed and continue to be closed to new entrants since April 1, 2009. The SERP provides future pension benefits to participants based on years of service and earnings.

Due to *Income Tax Act* (Canada) requirements, the SERP is subject to the RCA rules; therefore, approximately half of the assets are held in a non-interest bearing Refundable Tax Account with the Canada Revenue Agency. The remaining assets of the SERP are invested in a combination of Canadian equities and Canadian fixed income securities.

The obligations and costs of SERP benefits are determined annually through an actuarial valuation as at March 31 using the projected benefit method pro-rated on service. AHS uses a discount rate based on plan asset earnings to calculate the accrued benefit obligation.

The net SERP retirement benefit cost reported in these consolidated financial statements is comprised of the retirement benefits expense and the retirement benefits interest expense. Costs shown reflect the total estimated cost to provide annual pension income over an actuarially determined post employment period. The key components of retirement benefits expense include the cost of any plan amendments including related net actuarial gains or losses incurred in the period, gains and losses from any plan settlements or curtailments incurred in the period, and amortization of actuarial gains and losses. Retirement benefit costs are not cash payments in the period but are the period expense for rights to future compensation. The retirement benefits interest expense is net of the interest cost on the accrued benefit obligation and the expected return on plan assets.

The actuarial gains and losses that arise are accounted for in accordance with PSAS whereby AHS amortizes actuarial gains and losses from the liability or asset over the average remaining service life of the related employee group.

Prior period service costs arising from plan amendments are recognized in the period of the plan amendment. When an employee's accrued benefit obligation is fully discharged, all unrecognized amounts associated with that employee are fully recognized in the net retirement benefit cost in the following year.

(iv) Supplemental Pension Plan (SPP)

Subsequent to April 1, 2009, staff eligible for SERP are enrolled in a defined contribution SPP. Similar to the SERP, the SPP supplements the benefits under AHS registered plans that are limited by the *Income Tax Act* (Canada). AHS contributes a certain percentage of an eligible employee's pensionable earnings, in excess of the limits of the *Income Tax Act* (Canada). This plan provides participants with an account balance at retirement based on the contributions made to the plan and investment income earned on the contributions based on investment decisions made by the participant.

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Note 2 Significant Accounting Policies and Reporting Practices (continued)

(v) Sick Leave Liability

Sick leave benefits accumulate with employees' service and are provided by AHS to certain employee groups of AHS, as defined by employment agreements, to cover illness related absences that are outside of short-term and long-term disability coverage. Benefit amounts are determined and accumulate with reference to employees' final earnings at the time they are paid out. The cost of the accumulating non-vesting sick leave benefits is expensed as the benefits are earned.

AHS accrues its liabilities for accumulating non-vesting sick leave benefits but does not record a liability for sick leave benefits that do not accumulate beyond the current reporting period as these are renewed annually.

The accumulating non-vesting sick leave liability is actuarially determined using the projected benefit method pro-rated for service and management's best estimates of expected discount rate, inflation, rate of compensation increase, termination and retirement rates, and mortality. The liability associated with these benefits is calculated as the present value of expected future payments pro-rated for service.

Any resulting net actuarial gain (loss) is deferred and amortized on a straight-line basis over the expected average remaining service life of the related employee groups.

(vi) Other Benefits

AHS provides its employees with basic life, accidental death and dismemberment, short-term disability, long-term disability, extended health, dental, and vision benefits through benefits carriers. AHS fully accrues its obligations for employee non-pension future benefits.

(t) Liability for Contaminated Sites

Contaminated sites are a result of contamination being introduced into air, soil, water, or sediment of a chemical, organic or radioactive material or live organism that exceeds an environmental standard. The liability is recognized net of any expected recoveries. A liability for remediation of contaminated sites normally results from operations that are no longer in productive use and is recognized when all of the following criteria are met:

(i) an environmental standard exists;
(ii) contamination exceeds the environmental standard;
(iii) AHS is directly responsible or accepts responsibility;
(iv) it is expected that future economic benefits will be given up; and
(v) a reasonable estimate of the amount can be made.

(j) Measurement Uncertainty

The consolidated financial statements, by their nature, contain estimates and are subject to measurement uncertainty. Measurement uncertainty exists when there is a difference between the recognized or disclosed amount and another reasonably possible amount. The amount recorded for amortization of tangible capital assets is based on the estimated useful life of the related tangible capital assets while the recognition of expended deferred capital revenue depends on when the terms for the use of the funding are met and, when applicable, AHS complies with its communicated use of the funding. The amounts recorded for employee future benefits are based on estimated future cash flows. The provision for unpaid claims, allowance for doubtful accounts and accrued liabilities are subject to significant management estimates and assumptions. The establishment of the provision for unpaid claims relies on the judgment and opinions of many individuals; historical precedent and trends; prevailing legal, economic, social, and regulatory trends; and expectation as to future developments. The process of determining the provision necessarily involves risks that the actual results will deviate perhaps materially from the best estimates made. These estimates and assumptions are reviewed at least annually. Actual results could differ from the estimates determined by management in these consolidated financial statements, and these differences, which may be material, could require adjustment in subsequent reporting periods.

(k) Internally Restricted Surplus for Future Purposes

Certain amounts, as approved by the AHS Board, are set aside in accumulated surplus for use by AHS for future operating and capital purposes, to restrict amounts for legislatively required restricted equity and donation amounts restricted by 3rd parties. Transfers to or from internally restricted surplus for future purposes are recorded to the respective reserved surplus when approved.

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Note 2 Significant Accounting Policies and Reporting Practices (continued)

(l) Foreign Currency Translation

Transaction amounts denominated in foreign currencies are translated into their Canadian dollar equivalents at exchange rates prevailing at the transaction dates. Carrying values of monetary assets and liabilities and non-monetary items included in the fair value category reflect the exchange rates at the Consolidated Statement of Financial Position date. Unrealized foreign exchange gains and losses are recognized in the Consolidated Statement of Remeasurement Gains and Losses.

In the period of settlement, foreign exchange gains and losses are reclassified to the Consolidated Statement of Operations, and the cumulative amount of remeasurement gains and losses are reversed in the Consolidated Statement of Remeasurement Gains and Losses.

(m) Future Accounting Changes

The Public Sector Accounting Board has issued the following accounting standards in recent years:

- **PS 2200 – Related Party Disclosures (effective April 1, 2017)**
  PS 2200 defines a related party and establishes disclosures required for related party transactions.
- **PS 3420 – Inter-Entity Transactions (effective April 1, 2017)**
  PS 3420 establishes standards on how to account for and report transactions between public sector entities that comprise a government's reporting entity from both a provider and recipient perspective.
- **PS 3210 – Assets (effective April 1, 2017)**
  PS 3210 provides guidance for applying the definition of assets set out in PS 1000 – Financial Statement Concepts and establishes general disclosure standards for assets.
- **PS 3320 – Contingent Assets (effective April 1, 2017)**
  PS 3320 defines and establishes disclosure standards on contingent assets.
- **PS 3380 – Contractual Rights (effective April 1, 2017)**
  PS 3380 defines and establishes disclosure standards on contractual rights.
- **PS 3430 – Restructuring Transactions (effective April 1, 2018)**
  PS 3430 provides guidance on how to account for and report restructuring transactions by both transferors and recipients of assets and/or liabilities, together with related programs or operating responsibilities.

AHS' management is currently assessing what the impact of these new standards will be on future consolidated financial statements.

Note 3 Budget

The AHS Health Plan and Business Plan 2016-17, which included the 2016-17 annual budget, was approved by the Minister of Health on June 29, 2016.

Note 4 Other Government Transfers

	2017	2016
Unrestricted operating	$ 59,737	$ 60,272
Restricted operating (Note 14)	118,303	88,192
Recognition of expended deferred capital revenue (Note 16)	278,112	268,090
	$ 456,152	**$ 416,554**

Other government transfers include $449,067 (2016 – $409,882) transferred from the GOA and $7,085 (2016 – $6,672) from the federal government, and exclude amounts from AH as these amounts are separately disclosed on the Consolidated Statement of Operations.

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Note 5 Donations, Fundraising, and Non-Government Contributions

	2017	2016
Unrestricted operating	$ 4,597	$ 2,622
Restricted operating	120,120	119,111
Recognition of expended deferred capital revenue	37,991	41,488
Endowment contributions and reinvested income	1,308	3,585
	$ 164,016	**$ 166,806**

Note 6 Investment and Other Income

	2017	2016
Investment income	$ 65,552	$ 84,900
Other income:		
GOA (Note 21)	37,422	31,118
AH	19,166	20,371
Other[a]	148,270	131,542
	$ 270,410	**$ 267,931**

(a) Other includes revenue related to administrative services provided to other organizations of $15,547 (2016 – $10,906).

Note 7 Administration

	2017	2016
General administration[a]	$ 251,703	$ 221,472
Human resources[b]	92,695	91,370
Finance[c]	73,394	61,872
Communications[d]	21,354	22,078
Administration expense of full-spectrum contracted health service providers[e]	38,928	37,634
	$ 478,074	**$ 434,426**

(a) General administration includes senior leaders' expenses, the former Official Administrator expenses, Board expenses, and other administrative functions such as planning and development, privacy, risk management, internal audit, infection control, quality assurance, insurance, patient safety, and legal.

(b) Human resources includes personnel services, staff recruitment and selection, orientation, labour relations, employee health, and employee record keeping.

(c) Finance includes the recording, monitoring, and reporting of the financial and statistical aspects of AHS' planned and actual activities.

(d) Communications includes the receipt and transmission of AHS' communications including electronic communication, visitor information, and mail services. It also includes personnel dedicated to maintenance and repair of communication systems and devices.

(e) Administration expense of full spectrum contracted health service providers is AHS' estimate of the portion that AHS funds of the general administration, human resources, finance, and communication expenses incurred by service providers with whom AHS contracts for a full spectrum of health services.

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Note 8 Support Services

	2017	2016
Facilities operations	$ 869,181	$ 816,608
Patient: health records, food services, and transportation	385,444	373,682
Materials management	207,661	198,116
Housekeeping, laundry, and linen	208,380	192,342
Support services expense of full-spectrum contracted health service providers[a]	149,941	143,701
Ancillary operations	105,078	104,867
Fundraising expenses and grants awarded	42,866	48,028
Emergency preparedness services	6,808	4,353
Other	170,182	195,807
	$ 2,145,541	**$ 2,077,504**

(a) Support services expense of full spectrum contracted health service providers is AHS' estimate of the portion that AHS funds of the support services incurred by service providers with whom AHS contracts for a full spectrum of health services.

Note 9 Financial Instruments

AHS is exposed to a variety of financial risks associated with its financial instruments. These financial risks include market risk, credit risk, and liquidity risk.

(a) Market Risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk comprises three types of risk: price risk, interest rate risk, and foreign currency risk.

In order to earn financial returns at an acceptable level of market risk, each of the investment policies have established a targeted asset mix. The AHS Investment Bylaw & Policy has established asset mix ranges of 0% to 100% for cash and money market securities, 0% to 80% for fixed income securities, and 0% to 40% for equities.

The ACF Investment Policy has established an asset mix policy of 0% to 10% for money market securities, 30% to 60% for fixed income securities, and 30% to 70% for equities.

The LPIP Investment Policy has established an asset mix policy of 78% to 89% for cash and fixed income securities, 8% to 17% for equities, and 3% to 5% for real estate fund.

The CHT Statement of Investment Policies and Goals has established an asset mix policy of 30% to 70% for fixed income securities and 30% to 70% for equities.

Risk is reduced under all of the investment policies through asset class diversification, diversification within each asset class, and portfolio quality constraints.

AHS assesses the sensitivity of its portfolio to market risk based on historical volatility of equity and fixed income markets. The volatility is determined using a ten year average based on fixed income and equity market fluctuations and is applied to the total portfolio. Based on the volatility average of 2.76% (2016 – 2.69%) increase or decrease, with all other variables held constant, the increase or decrease in accumulated remeasurement gains and losses and unrealized net gains and losses attributable to deferred revenue and endowments would be $48,779 (2016 – $45,939).

(i) Price Risk

Price risk relates to the possibility that equity investments will change in fair value due to future fluctuations in market prices caused by factors specific to an individual equity investment or other factors affecting all equities traded in the market. AHS is exposed to price risk associated with the underlying equity investments held in pooled funds. If equity market indices (S&P/TSX, S&P1500 and MSCI ACWI and their sectors) declined by 10%, and all other variables are held constant, the potential loss in fair value to AHS would be approximately $51,363 or 2.27% of total investments (March 31, 2016 – $46,236 or 2.11%).

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Note 9 Financial Instruments (continued)

(ii) Interest Rate Risk

Interest rate risk is the risk that the value of a financial instrument might be adversely affected by a change in market interest rates. Changes in market interest rates may have an effect on the cash flows associated with some financial assets and liabilities, known as cash flow risk, and on the fair value of other financial assets or liabilities, known as price risk. AHS manages the interest rate risk exposure of its fixed income investments by management of average duration and laddered maturity dates.

AHS is exposed to interest rate risk through its investments in fixed income securities with both fixed and floating interest rates. AHS has fixed interest rate loans for all debt, thereby mitigating interest rate risk from rate fluctuations over the term of the outstanding debt. The fair value of fixed rate debt fluctuates with changes in market interest rates but the related future cash flows will not change.

In general, investment returns for bonds and mortgage funds are sensitive to changes in the level of interest rates, with longer term interest bearing securities being more sensitive to interest rate changes than shorter term bonds.

A 1% change in market yield relating to fixed income securities would have increased or decreased fair value by approximately $68,009 (March 31, 2016 – $65,654).

Fixed income securities include bonds and money market securities. The fixed income securities have the following average maturity structure ranging from 2017 and 2067.:

	2017	2016
0 – 5 years	78%	76%
6 – 10 years	13%	13%
Over 10 years	9%	11%

	Effective Market Yield			Average Effective Market Yield
Asset Class	< 1 year	1-5 years	> 5 years	
Interest bearing securities	1.28%	1.31%	2.69%	1.76%

(iii) Foreign Currency Risk

Foreign currency risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in foreign exchange rates. The fair value of cash and investments denominated in foreign currencies is translated into Canadian dollars on a daily basis using the reporting date exchange rate. AHS is exposed to foreign exchange fluctuations on its cash denominated in foreign currencies. At March 31, 2017, no investment balances were denominated in foreign currency (2016 – $nil).

Foreign currency risk is managed by the fact that the investment policies limit non-Canadian equities to a maximum of 10% to 45% of the total investment portfolio, depending on the policy. At March 31, 2017, investments in non-Canadian equities represented 15.7% (March 31, 2016 – 13.40%) of total portfolio investments.

Foreign exchange fluctuations on cash balances are mitigated by forward contracts and holding minimal foreign currency cash balances. At March 31, 2017, AHS held US dollar forward contracts with ATB Financial to manage currency fluctuations relating to its US dollar accounts payable requirements. As at March 31, 2017, AHS held derivatives in the form of forward contracts for future settlement of $18,000 (2016 – $24,000). The fair value of these forward contracts as at March 31, 2017 was a gain of $501 (2016 – loss of $141) and is included in investments (Note 10).

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Note 9 Financial Instruments (continued)

(b) Credit Risk

Credit risk is the risk of loss arising from the failure of a counterparty to fully honour its financial obligations. The credit quality of financial assets is generally assessed by reference to external credit ratings. Credit risk can also lead to losses when issuers and debtors are downgraded by credit rating agencies. All of the investment policies restrict the types and proportions of eligible investments, thus mitigating AHS' exposure to credit risk.

Accounts receivable primarily consists of amounts receivable from AH, other Alberta government reporting entities, patients, other provinces and territories, Workers' Compensation Board, and the federal government. AHS periodically reviews the collectability of its accounts receivable and establishes an allowance based on its best estimate of potentially uncollectible amounts.

Under the AHS Investment Bylaw, money market securities are limited to a rating of R1 or equivalent or higher, and no more than 10% may be invested in any one issuer. Investments in corporate bonds are limited to BBB or equivalent rated bonds or higher and no more than 40% of the total fixed income securities. Investments in debt and equity of any one issuer are limited to 5% of the issuer's total debt and equity. AHS holds unrated mortgage fund investments. Short selling is not permitted.

The ACF Investment Policy limits the overall rating of all fixed income instruments to at least an A rating, and no more than 10% of publicly traded equities may be invested in any one issuer.

The LPIP Investment Policy limits money market securities to a rating of R1 or equivalent or higher, and no more than 10% may be invested in any one issuer, unless guaranteed by the Government of Canada or a Canadian province. Investments in corporate bonds are limited to BBB or equivalent rated bonds or higher. Investments in debt and equity of any one issuer are limited to 10% of total equities. LPIP holds unrated mortgage fund investments.

The CHT Statement of Investment Policies and Goals limits the overall rating of fixed income securities to BBB or equivalent or higher, and no more than 10% of fixed income securities or equities may be invested in any one issuer.

The following table summarizes AHS' investment in debt securities by counterparty credit rating at March 31, 2017.

Credit Rating	2017	2016
Investment Grade (AAA to BBB-)	90%	90%
Unrated	10%	10%
	100%	**100%**

(c) Liquidity Risk

Liquidity risk is the risk that AHS will encounter difficulty in meeting obligations associated with financial liabilities that are settled by delivery of cash or another financial asset. Liquidity requirements of AHS are met through funding in advance by AH, income generated from investments, and by investing in liquid assets, such as money market investments, equities, and bonds traded in an active market that are easily sold and converted to cash.

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Note 10 Investments

	2017		2016	
	Fair Value	Cost	Fair Value	Cost
Cash held for investments	$ 106,666	$ 106,666	$ 108,650	$ 108,650
Interest bearing securities:				
Money market securities	101,113	101,113	139,986	139,986
Fixed income securities	1,543,462	1,546,500	1,476,511	1,466,168
	1,644,575	1,647,613	1,616,497	1,606,154
Equities:				
Canadian public pooled equity funds	157,446	136,403	169,064	155,830
Global public pooled equity funds	356,179	312,159	293,295	283,265
	513,625	448,562	462,359	439,095
	$ 2,264,866	$ 2,202,841	$ 2,187,506	$ 2,153,899

	2017	2016
Items at Fair Value		
Financial instruments designated to the fair value category	$ 1,750,740	$ 1,725,288
Portfolio investments in equity instruments that are quoted in an active market	513,625	462,359
Derivatives	501	(141)
	$ 2,264,866	$ 2,187,506

Included in the investments is $161,134 (March 31, 2016 – $147,572) that is restricted for use as per the requirements in Sections 99 and 100 of the Insurance Act of Alberta. Endowments included in investments amount to $74,710 (March 31, 2016 – $73,402).

As AHS is comprised of multiple entities as described in Note 2(a), investments are governed independently under multiple investment policies and procedures. The fair value of investments governed under each investment policy is as follows:

	2017	2016
AHS Investment Bylaw & Policy	$ 1,801,679	$ 1,752,970
ACF Investment Policy	160,219	153,158
LPIP Investment Policy	184,000	176,610
CHT Statement of Investment Policies and Goals	118,968	104,768
	$ 2,264,866	$ 2,187,506

Investments are measured at fair value with the differences between cost and fair value being recorded as a remeasurement gain or loss or recorded as deferred revenue.

The following are the total net remeasurement gains on investments:

	2017	2016
Accumulated remeasurement gains	$ 28,866	$ 5,022
Restricted unrealized net gains attributable to unexpended deferred operating revenue and endowments (Note 14(b))	32,811	28,558
Restricted unrealized net gains attributable to unexpended deferred capital revenue (Note 15(b))	348	27
	$ 62,025	$ 33,607

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Note 10 Investments (continued)

Fair Value Hierarchy

	2017			
	Level 1	Level 2	Level 3	Total
Cash held for investments	$ 106,666	$ -	$ -	$ 106,666
Interest bearing securities:				
Money market securities	-	101,113	-	101,113
Fixed income securities	-	1,406,541	136,921	1,543,462
Equities:				
Canadian public pooled equity funds	156,154	1,292	-	157,446
Global public pooled equity funds	254,321	101,858	-	356,179
	$ 517,141	**$ 1,610,804**	**$ 136,921**	**$ 2,264,866**
Percent of total	23%	71%	6%	100%

	2016			
	Level 1	Level 2	Level 3	Total
Cash held for investments	$ 108,650	$ -	$ -	$ 108,650
Interest bearing securities:				
Money market securities	-	139,986	-	139,986
Fixed income securities	-	1,351,309	125,202	1,476,511
Equities:				
Canadian public pooled equity funds	167,817	1,247	-	169,064
Global public pooled equity funds	193,722	99,573	-	293,295
	$ 470,189	**$ 1,592,115**	**$ 125,202**	**$ 2,187,506**
Percent of total	21%	73%	6%	100%

Note 11 Accounts Receivable

	2017			2016
	Gross	Allowance for Doubtful Accounts	Net	Net
Patient accounts receivable	$ 109,658	$ 24,301	$ 85,357	$ 98,632
AH operating transfers receivable	89,247	-	89,247	72,387
Other operating transfers receivable	45,810	-	45,810	20,984
Other capital transfers receivable	82,797	-	82,797	116,888
Other accounts receivable	83,103	22	83,081	84,602
	$ 410,615	**$ 24,323**	**$ 386,292**	**$ 393,493**

At March 31, 2016, the total allowance for doubtful accounts was $29,199.

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Note 12 Accounts Payable and Accrued Liabilities

	2017	2016
Payroll remittances payable and related accrued liabilities	$ 523,543	$ 651,578
Trade accounts payable and accrued liabilities[a]	470,126	371,670
Provision for unpaid claims[b]	141,233	136,378
Other liabilities	43,431	42,496
Obligations under capital leases[c]	31,641	34,190
	$ 1,209,974	**$ 1,236,312**

(a) Trade Accounts Payable and Accrued Liabilities

Trade accounts payable and accrued liabilities includes payables related to the purchase of tangible capital assets of $82,878 (2016 – $57,445).

(b) Provision for Unpaid Claims

Provision for Unpaid Claims is an estimate of liability claims within AHS. It is influenced by factors such as historical trends involving claim payment patterns, pending levels of unpaid claims, claims severity and claim frequency patterns.

The provision has been estimated using the discounted value of claim liabilities using a discount rate of 2.20% (2016 – 1.95%) plus a provision for adverse deviation, based on actuarial estimates.

(c) Obligations under Capital Leases

Capital leases include a site lease with the University of Calgary, a site lease for the Northern Communications Centre in Peace River, and vehicle leases.

The University of Calgary lease expires January 2028. The implicit interest rate payable on this lease is 6.50% (2016 – 6.50%). There are no renewal options, purchase options or escalation clauses related to this capital lease.

The Northern Communications Centre site lease expires May 2036. The implicit interest rate payable on this lease is 3.40% (2016 – 3.40%). The lease has an option to renew for two additional terms of 5 years each.

AHS is committed to making payments for obligations under capital leases as follows:

Year ended March 31	Minimum Lease Payments
2018	$ 3,889
2019	3,388
2020	2,909
2021	2,731
2022	2,754
Thereafter	27,772
	43,443
Less: interest	(11,802)
	$ 31,641

(d) Liability for Contaminated Sites

At March 31, 2017, AHS has not identified or accepted any liability for contaminated sites (2016 – $nil).

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Note 13 Employee Future Benefits

	2017	2016
Accrued vacation pay	$ 540,547	$ 514,672
Accumulating non-vesting sick leave liability[a]	112,490	106,015
Registered defined benefit pension plans[b] [c]	-	-
	$ 653,037	**$ 620,687**

(a) Accumulating Non-Vesting Sick Leave Liability

Sick leave benefits are paid by AHS; there are no employee contributions and no assets set aside to support the obligation.

The AHS sick leave liability is based on an actuarial valuation as at March 31, 2015, and extrapolated to March 31, 2017 by AHS. The next actuarial valuation will be performed as at March 31, 2018.

The following table summarizes the accumulating non-vesting sick leave liability.

	2017	2016
Change in accrued benefit obligation and funded status		
Accrued benefit obligation and funded status, beginning of year	$ 118,969	$ 114,979
Current service cost	10,262	9,939
Interest cost	3,621	3,486
Benefits paid	(8,675)	(9,435)
Actuarial gain	(9,000)	-
Accrued benefit obligation and funded status, end of year	**$ 115,177**	**$ 118,969**
Reconciliation to accrued benefit liability		
Funded status – deficit	$ 115,177	$ 118,969
Unamortized net actuarial loss	(2,687)	(12,954)
Accrued benefit liability	**$ 112,490**	**$ 106,015**
Components of expense		
Current service cost	$ 10,262	$ 9,939
Interest cost	3,621	3,486
Amortization of net actuarial loss	1,267	1,267
Net expense	**$ 15,150**	**$ 14,692**
Assumptions		
Discount rate – beginning of year	2.90%	2.90%
Discount rate – end of year	2.02%	2.90%
Rate of compensation increase per year	2016-2017	2015-2016
	2.43%	3.21%
	2017-2018	2016-2017
	0.75%	2.43%
	Thereafter	Thereafter
	2.75%	3.25%

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Note 13 Employee Future Benefits (continued)

(b) Local Authorities Pension Plan (LAPP)

(i) AHS Participation in the LAPP

The majority of AHS employees participate in the LAPP. AHS is not responsible for future funding of the plan deficit other than through contribution increases. As AHS is exposed to the risk of contribution rate increases, the following disclosure is provided to explain this risk.

The LAPP provides for a pension of 1.4% for each year of pensionable service based on the average salary of the highest five consecutive years up to the average Canada Pension Plan's Year's Maximum Pensionable Earnings (YMPE), over the same five consecutive year period and 2.0% on the excess, subject to the maximum pension benefit limit allowed under the *Income Tax Act* (Canada). The maximum pensionable service allowable under the plan is 35 years.

(ii) LAPP Deficit

An actuarial valuation of the LAPP was carried out as at December 31, 2015 by Mercer (Canada) Limited and these results were then extrapolated to December 31, 2016 for use in the LAPP 2016 audited financial statements. LAPP's December 31, 2016 net assets available for benefits divided by LAPP's pension obligation shows that the LAPP is 98% (2015 – 97%) funded.

	December 31, 2016	December 31, 2015
LAPP net assets available for benefits	$ 37,722,943	$ 34,419,584
LAPP pension obligation	38,360,300	35,343,000
LAPP deficiency	**$ (637,357)**	**$ (923,416)**

The 2016 and 2017 LAPP contribution rates are as follows:

Calendar 2017		Calendar 2016	
Employer	Employees	Employer	Employees
11.39% of pensionable earnings up to the YMPE and 15.84% of the excess	10.39% of pensionable earnings up to the YMPE and 14.84% of the excess	11.39% of pensionable earnings up to the YMPE and 15.84% of the excess	10.39% of pensionable earnings up to the YMPE and 14.84% of the excess

(c) Pension Expense

	2017	2016
Local Authorities Pension Plan	$ 595,795	$ 570,438
Defined contribution pension plans and group RRSPs	48,397	46,763
Supplemental Pension Plan	2,230	1,882
Supplemental Executive Retirement Plans	2,240	(788)
Management Employees Pension Plan	585	668
	$ 649,247	**$ 618,963**

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Note 14 Unexpended Deferred Operating Revenue

(a) Changes in the unexpended deferred operating revenue balance are as follows:

	2017				2016
	AH	Other Government[1]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 153,253	$ 25,055	$ 251,207	$ 429,515	$ 491,254
Received or receivable during the year, net of repayments	927,960	76,747	134,360	1,139,067	1,210,987
Restricted investment income	253	1,645	5,818	7,716	6,579
Transferred from (to) unexpended deferred capital revenue	3,696	60,529	(16,764)	47,461	48,395
Recognized as revenue	(953,328)	(118,303)	(120,120)	(1,191,751)	(1,272,042)
Miscellaneous other revenue recognized	(196)	(5)	(24,981)	(25,182)	(25,891)
	131,638	**45,668**	**229,520**	**406,826**	**459,282**
Changes in unrealized net gains attributable to portfolio investments related to endowments and unexpended deferred operating revenue	(1,783)	18	6,018	4,253	(29,767)
Balance, end of year	**$ 129,855**	**$ 45,686**	**$ 235,538**	**$ 411,079**	**$ 429,515**

[1] The balance at March 31, 2017 for other government includes $582 of unexpended deferred operating revenue received from the federal government (March 31, 2016 – $549). The remaining balance in other government all relates to the GOA, see Note 21.

(b) The unexpended deferred operating revenue balance at the end of the year is externally restricted for the following purposes:

	2017				2016
	AH	Other Government	Donors and Non-Government	Total	Total
Research and education	$ 19,263	$ 3,080	$ 134,835	$ 157,178	$ 158,148
Cancer prevention, screening and treatment	27,454	-	711	28,165	18,861
Physician revenue and alternate relationship plans	26,129	1,112	-	27,241	21,660
Promotion, prevention and community	6,748	19,486	605	26,839	14,120
Addiction and mental health	20,912	-	-	20,912	19,330
Primary Care Networks	19,372	-	-	19,372	44,146
Long term care partnerships	-	17,227	-	17,227	15,479
Emergency and outpatient services	2,297	305	1,413	4,015	11,033
Administration and support services	4,852	3,361	51,161	59,374	67,240
Others less than $10,000	4,588	1,095	12,262	17,945	30,940
	131,615	**45,666**	**200,987**	**378,268**	**400,957**
Unrealized net gain (loss) attributable to portfolio investments related to endowments and unexpended deferred operating revenue (Note 10)	(1,760)	20	34,551	32,811	28,558
	$ 129,855	**$ 45,686**	**$ 235,538**	**$ 411,079**	**$ 429,515**

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Note 15 Unexpended Deferred Capital Revenue

(a) Changes in the unexpended deferred capital revenue balance are as follows:

	2017				2016
	AH	Other Government[1]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 57,916	$ 9,175	$ 81,228	$ 148,319	$ 178,078
Received or receivable during the year	30,300	184,468	29,371	244,139	194,567
Transferred tangible capital assets (Note 18(a))	-	215,933	-	215,933	399,992
Restricted investment income	-	-	-	-	63
Unexpended deferred capital revenue returned	-	-	(1,220)	(1,220)	(4,698)
Transfer to expended deferred capital revenue	(45,285)	(332,402)	(43,851)	(421,538)	(561,027)
Used for the acquisition of land	-	(687)	-	(687)	-
Transferred (to) from unexpended deferred operating revenue	(3,696)	(60,529)	16,764	(47,461)	(48,395)
	39,235	**15,958**	**82,292**	**137,485**	**158,580**
Changes in unrealized net gain on portfolio investments related to unexpended deferred capital revenue	321	-	-	321	(10,261)
Balance, end of year	**$ 39,556**	**$ 15,958**	**$ 82,292**	**$ 137,806**	**$ 148,319**

[1] The balance at March 31, 2017 for other government all relates to the GOA, see Note 21.

(b) The unexpended deferred capital revenue balance at the end of the year is externally restricted for the following purposes:

	2017	2016
AH		
Information systems less than $10,000	$ 32,504	$ 38,741
Medical Equipment Replacement Upgrade Program	18	11,367
Equipment less than $10,000	6,686	7,781
Total AH	**39,208**	**57,889**
Other government		
Facilities and improvements less than $10,000	15,958	9,176
Total other government	**15,958**	**9,176**
Donors and non-government		
Equipment less than $10,000	80,482	73,918
Facilities and improvements less than $10,000	1,810	7,309
Total donors and non-government	**82,292**	**81,227**
Unrealized net gain on portfolio investments related to unexpended deferred capital revenue (Note 10)	348	27
	$ 137,806	**$ 148,319**

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Note 16 Expended Deferred Capital Revenue

Changes in the expended deferred capital revenue balance are as follows:

	2017				2016
	AH	Other Government[1]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 297,812	$ 6,056,411	$ 176,209	$ 6,530,432	$ 6,363,699
Transferred from unexpended deferred capital revenue	45,285	332,402	43,851	421,538	561,027
Used for the acquisition of land	-	687	-	687	-
Less: amounts recognized as revenue	(86,784)	(278,112)	(37,991)	(402,887)	(394,294)
Balance, end of year	**$ 256,313**	**$ 6,111,388**	**$ 182,069**	**$ 6,549,770**	**$ 6,530,432**

[1] The balance at March 31, 2017 for other government includes $78 of expended deferred capital revenue received from the federal government (March 31, 2016 – $nil). The remaining balance in other government all relates to the GOA, see Note 21.

Note 17 Debt

	2017	2016
Debentures payable[(a)]:		
Parkade loan #1	$ 32,223	$ 34,903
Parkade loan #2	30,278	32,505
Parkade loan #3	39,089	41,432
Parkade loan #4	147,262	154,086
Parkade loan #5	35,605	37,204
Parkade loan #6	24,418	25,300
Parkade loan #7[(b)]	51,500	-
Energy savings initiative loan[(b)]	25,800	-
Other	1,212	1,479
	387,387	326,909
Loan proceeds to be received[(b)]	(67,300)	-
	$ 320,087	**$ 326,909**

(a) AHS issued debentures to Alberta Capital Financing Authority (ACFA), a related party, to finance the construction of parkades. AHS has pledged revenue derived directly or indirectly from the operations of all parking facilities being built, renovated, owned, and operated by AHS as security for these debentures.

AHS issued a debenture to ACFA relating to an energy savings initiative. AHS has pledged the mortgage on the Royal Alexandra Lands and Alberta Hospital Lands as security for this debenture.

The maturity dates and interest rates for the debentures are as follows:

	Maturity Date	Fixed Interest Rate
Parkade loan #1	September 2026	4.4025%
Parkade loan #2	September 2027	4.3870%
Parkade loan #3	March 2029	4.9150%
Parkade loan #4	September 2031	4.9250%
Parkade loan #5	June 2032	4.2280%
Parkade loan #6	December 2035	3.6090%
Parkade loan #7	March 2038	2.6400%
Energy savings initiative loan	December 2030	2.4160%
Other	March 2021	4.6000%

(b) At March 31, 2017, $5,000 of $51,500 had been advanced to AHS relating to the Foothills Medical Centre Lot 1 parkade debenture with the remainder to be drawn by March 2018. Semi-annual principal and interest payments of $1,665 will commence September 2018. At March 31, 2017, $5,000 of $25,800 had been advanced to AHS relating to the Energy Savings initiative with the remainder to be drawn by December 2017. Semi-annual principal and interest payments of $1,162 will commence June 2018.

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Note 17 Debt (continued)

AHS is committed to making payments as follows:

Year ended March 31	Debentures Payable, Term/Other Loan and Mortgages Payable Principal Payments
2018	$ 17,612
2019	22,133
2020	23,091
2021	24,092
2022	24,800
Thereafter	275,659
	$ 387,387

During the year, the amount of total interest expensed, including interest related to obligations under capital leases, was $16,221 (2016 – $15,249).

(c) As at March 31, 2017, AHS has access to a $220,000 (March 31, 2016 – $220,000) revolving demand facility with a Canadian chartered bank which may be used for operating purposes. Draws on the facility bear interest at the bank's prime rate less 0.50% per annum. As at March 31, 2017, AHS has $nil (March 31, 2016 – $nil) draws against this facility.

AHS also has access to a $33,000 (March 31, 2016 – $33,000) revolving demand letter of credit facility which may be used to secure AHS' obligations to third parties. At March 31, 2017, AHS has $3,469 (March 31, 2016 – $3,664) in a letter of credit outstanding against this facility. AHS is in compliance with the terms of the agreement relating to the letter of credit, therefore no liability has been recorded.

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Note 18 Tangible Capital Assets

Cost	2016	Additions[a]	Transfers out of Work in Progress	Disposals	2017
Facilities and improvements	$ 8,488,610	$ -	$ 510,770	$ (2,625)	$ 8,996,755
Work in progress	1,086,124	418,267	(590,285)	-	914,106
Equipment[b]	2,179,617	153,429	1,256	(31,483)	2,302,819
Information systems	1,331,861	24,391	17,754	(11,350)	1,362,656
Building service equipment	567,261	-	43,815	(55)	611,021
Land[c]	110,069	687	-	(167)	110,589
Leased facilities and improvements	219,937	247	4,784	-	224,968
Land improvements	70,919	-	11,906	(61)	82,764
	$ 14,054,398	**$ 597,021**	**$ -**	**$ (45,741)**	**$ 14,605,678**

Accumulated Amortization	2016	Amortization Expense	Effect of Transfers	Disposals	2017
Facilities and improvements	$ 3,179,295	$ 236,203	$ -	$ (2,626)	$ 3,412,872
Work in progress	-	-	-	-	-
Equipment[b]	1,678,226	155,393	-	(31,084)	1,802,535
Information systems	1,081,472	110,696	-	(11,350)	1,180,818
Building service equipment	332,616	32,449	-	(49)	365,016
Land[c]	-	-	-	-	-
Leased facilities and improvements	149,431	12,891	-	-	162,322
Land improvements	60,287	2,812	-	(61)	63,038
	$ 6,481,327	**$ 550,444**	**$ -**	**$ (45,170)**	**$ 6,986,601**

	Net Book Value	
	2017	2016
Facilities and improvements	$ 5,583,883	$ 5,309,315
Work in progress	914,106	1,086,124
Equipment	500,284	501,391
Information systems	181,838	250,389
Building service equipment	246,005	234,645
Land	110,589	110,069
Leased facilities and improvements	62,646	70,506
Land improvements	19,726	10,632
	$ 7,619,077	**$ 7,573,071**

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Note 18 Tangible Capital Assets (continued)

Cost	2015	Additions[a]	Transfers out of Work in Progress	Disposals	2016
Facilities and improvements	$ 8,287,500	$ -	$ 201,923	$ (813)	$ 8,488,610
Work in progress	834,328	524,033	(272,237)	-	1,086,124
Equipment[b]	2,185,995	104,390	4,985	(115,753)	2,179,617
Information systems	1,349,427	4,420	25,595	(47,581)	1,331,861
Building service equipment	539,452	-	27,834	(25)	567,261
Land[c]	110,069	-	-	-	110,069
Leased facilities and improvements	191,866	17,942	10,129	-	219,937
Land improvements	69,148	-	1,771	-	70,919
	$ 13,567,785	**$ 650,785**	**$ -**	**$ (164,172)**	**$ 14,054,398**

Accumulated Amortization	2015	Amortization Expense	Effect of Transfers	Disposals	2016
Facilities and improvements	$ 2,955,848	$ 224,212	$ -	$ (765)	$ 3,179,295
Work in progress	-	-	-	-	-
Equipment[b]	1,602,510	191,046	-	(115,330)	1,678,226
Information systems	1,000,609	128,444	-	(47,581)	1,081,472
Building service equipment	304,910	27,731	-	(25)	332,616
Land[c]	-	-	-	-	-
Leased facilities and improvements	134,819	14,612	-	-	149,431
Land improvements	57,952	2,335	-	-	60,287
	$ 6,056,648	**$ 588,380**	**$ -**	**$ (163,701)**	**$ 6,481,327**

	Net Book Value	
	2016	2015
Facilities and improvements	$ 5,309,315	$ 5,331,652
Work in progress	1,086,124	834,328
Equipment	501,391	583,485
Information systems	250,389	348,818
Building service equipment	234,645	234,542
Land	110,069	110,069
Leased facilities and improvements	70,506	57,047
Land improvements	10,632	11,196
	$ 7,573,071	**$ 7,511,137**

(a) Transferred Tangible Capital Assets

Additions include total transferred tangible capital assets of $215,933 (2016 – $399,992) consisting of $215,933 from AI (2016 – $399,927) and $nil from other sources (2016 – $65).

(b) Leased Equipment

Equipment includes tangible capital assets acquired through capital leases at a cost of $13,417 (2016 – $15,694) with accumulated amortization of $11,266 (March 31, 2016 – $11,859). For the year ended March 31, 2017, leased equipment included a net decrease of $1,137 related to vehicles under capital leases (2016 – net decrease of $362).

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Note 18 Tangible Capital Assets (continued)

(c) Leased Land

Land at the following sites has been leased to AHS at nominal values:

Site	Leased from	Lease Expiry
Cross Cancer Institute Parkade	University of Alberta	2019
Evansburg Community Health Centre	Yellowhead County	2031
Myrnam Land	Eagle Hill Foundation	2038
Two Hills Helipad	Stella Stefiuk	2041
McConnell Place North	City of Edmonton	2044
Northeast Community Health Centre	City of Edmonton	2047
Foothills Medical Centre Parkade	University of Calgary	2054
Alberta Children's Hospital	University of Calgary	2103

Note 19 Accumulated Surplus

Accumulated surplus is comprised of the following:

	2017					2016
	Unrestricted Surplus[a]	Internally Restricted Surplus for Future Purposes[b]	Invested in Tangible Capital Assets[c]	Endowments[d]	Total	Total
Balance, beginning of year	$ 125,480	$ 283,814	$ 676,427	$ 73,402	$ 1,159,123	$ 1,303,682
Annual operating surplus (deficit)	66,536	-	-	-	66,536	(144,559)
Tangible capital assets purchased with internal funds	(166,783)	-	166,783	-	-	-
Amortization of internally funded tangible capital assets	148,128	-	(148,128)	-	-	-
Repayment of debt used to fund tangible capital assets	(16,822)	-	16,822	-	-	-
Payments on obligations under capital leases	(1,655)	-	1,655	-	-	-
Net repayment of life lease deposits	(59)	-	59	-	-	-
Transfer of revenue for acquisition of land	(687)	-	687	-	-	-
Transfer of internally restricted	58,885	(58,885)	-	-	-	-
Transfer of endowment contributions	(1,308)	-	-	1,308	-	-
Balance, end of year	**$ 211,715**	**$ 224,929**	**$ 714,305**	**$ 74,710**	**$ 1,225,659**	**$ 1,159,123**

(a) Unrestricted Surplus

Unrestricted surplus represents the portion of accumulated surplus that has not been internally restricted for future purposes, invested in tangible capital assets, or endowments.

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Note 19 Accumulated Surplus (continued)

(b) Internally Restricted Surplus for Future Purposes

The Board has approved the restriction of accumulated surplus for future purposes as follows:

	2017	2016
Ancillary services [i]	$ 112,718	$ 92,842
Insurance equity requirements [ii]	42,224	41,431
Foundations [iii]	39,987	34,545
Other [iv]	30,000	114,996
Internally restricted surplus for future purposes	**$ 224,929**	**$ 283,814**

(i) Restriction of ancillary operation surpluses from parking, retail food services, and controlled entities' (2015-16 Restriction of ancillary operation surpluses for parking and retail food services).
(ii) Restriction of surplus related to equity of the LPIP (2015-16 Restriction of surplus related to equity of the LPIP).
(iii) Restriction of surplus related to AHS Controlled Foundations (2015-16 Restriction of surplus for specific local initiatives as a result of local fundraising, and to fund cancer research).
(iv) Restriction of surplus to address funding of expenses for certain initiatives spanning multiple fiscal years (2015-16 Restriction of surplus related to future capital purposes and the Provincial Clinical Information Systems Initiative (CIS)).

(c) Invested in Tangible Capital Assets

The restriction of accumulated surplus is equal to the net book value of internally funded tangible capital assets as these amounts are only available to AHS for its health care mandate.

(d) Endowments

Endowments represent the portion of accumulated surplus that is restricted and must be maintained in perpetuity.

Note 20 Contractual Obligations and Contingent Liabilities

Contractual obligations are AHS' obligations to others that will become liabilities in the future when the terms of current or existing contracts or agreements are met.

(a) Leases

AHS is contractually committed to future operating lease payments as follows:

Year ended March 31	Total Lease Payments
2018	$ 53,243
2019	45,999
2020	38,259
2021	32,055
2022	29,679
Thereafter	69,215
	$ 268,450

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Note 20 Contractual Obligations and Contingent Liabilities (continued)

(b) Contingent Liabilities

AHS is subject to legal claims during its normal course of business. AHS records a liability when the assessment of a claim indicates that a future event is likely to confirm that an asset had been impaired or a liability incurred at the date of the financial statements and the amount of the contingent loss can be reasonably estimated.

Accruals have been made in specific instances where it is likely that losses will be incurred based on a reasonable estimate. As at March 31, 2017, accruals have been recorded as part of the provision for unpaid claims and other liabilities (Note 12). Included in this accrual are claims in which AHS has been jointly named with the Minister. The accrual provided for these claims under the provision for unpaid claims represents AHS' portion of the liability.

AHS has been named in 186 legal claims (2016 – 176 claims) related to conditions in existence at March 31, 2017 where the likelihood of the occurrence of a future event confirming a contingent loss is not reasonably determinable. Of these, 179 claims have $310,941 in specified amounts and 7 have no specified amounts (2016 – 162 claims with $240,665 of specified claims and 14 claims with no specified amounts). The resolution of indeterminable claims may result in a liability, if any, that is different than the claimed amount.

AHS has been named as a co-defendant, along with the GOA, in a certified Class Action (the Claim) arising from increases to long-term accommodation charges implemented by Alberta Government regulations enacted on and after August 1, 2003, and paid by residents of long-term care facilities. The likelihood of the Claim is considered by AHS to be indeterminable, and the amount of the Claim has not yet been specified.

Note 21 Related Parties

Transactions with the following related parties are considered to be undertaken on similar terms and conditions to those adopted if the entities were dealing at arm's length. Amounts due to or from the related parties and the recorded amounts of the transactions are included within these consolidated financial statements, unless otherwise stated.

AH appoints all members of the AHS Board. The viability of AHS' operations depends on transfers from AH. Transactions between AHS and AH are reported and disclosed in the Consolidated Statement of Operations, the Consolidated Statement of Financial Position, and the Notes to the Consolidated Financial Statements, and are therefore excluded from the table below.

Related parties also include key management personnel of AHS. Related party transactions with key management personnel primarily consist of compensation related payments to employees and senior management and are considered to be undertaken on similar terms and conditions to those adopted if the entities were dealing at arm's length.

AHS is considered to be a related party with those entities consolidated or included on a modified equity basis in the GOA consolidated financial statements. Transactions between AHS and the other ministries that are undertaken on similar terms and conditions to those adopted if the entities were dealing at arm's length are recorded at their exchange amount as follows:

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Note 21 Related Parties (continued)

	Revenues[a]		Expenses	
	2017	2016	2017	2016
Ministry of Advanced Education[b]	$ 52,621	$ 52,564	$ 122,527	$ 120,194
Ministry of Infrastructure[c]	373,253	340,028	24,538	24,796
Other ministries[d]	60,865	49,096	29,341	29,814
Total for the year	**$ 486,739**	**$ 441,688**	**$ 176,406**	**$ 174,804**

	Receivable from		Payable to	
	2017	2016	2017	2016
Ministry of Advanced Education [b]	$ 5,536	$ 5,131	$ 26,449	$ 19,009
Ministry of Infrastructure [c]	23,623	49,688	-	-
Other ministries [d]	30,412	11,318	322,157	329,757
Balance, end of year	**59,571**	**66,137**	**348,606**	**348,766**

(a) Revenues with GOA ministries include other government transfers of $449,067 (2016 – $409,882), (Note 4), other income of $37,422 (2016 – $31,118), (Note 6), and fees and charges of $250 (2016 – $688).

(b) Most of AHS transactions with the Ministry of Advanced Education relate to initiatives with the University of Alberta and the University of Calgary. These initiatives include teaching, research, and program delivery. A number of physicians are employed by either AHS or the universities but perform services for both. Due to proximity of locations, some initiatives result in sharing physical space and support services. The revenue and expense transactions are a result of grants provided from one to the other and recoveries of shared costs.

(c) The transactions with the Ministry of Infrastructure relate to the construction and funding of tangible capital assets. These transactions include operating transfers of $71,225 (2016 – $47,634) and recognition of expended deferred capital revenue of $277,660 (2016 – $268,090) relating to tangible capital assets with stipulations or external restrictions to utilize over their remaining useful lives. AHS has also recorded an in-kind transfer and expense of $24,368 (2016 – $24,304) for space that is provided by AI rent free. Not included in the table above but included in total amounts disclosed in Note 18(a) is the transfer of tangible capital assets from AI of $215,933 (2016 – $399,927).

(d) The payable transactions with other ministries include the debt payable to ACFA (Note 17(a)).

At March 31, 2017, AHS has recorded deferred revenue from other ministries within the GOA, excluding AH, of $45,104 (March 31, 2016 – $24,506) related to unexpended deferred operating revenue (Note 14), $15,958 (March 31, 2016 – $9,176) related to unexpended deferred capital revenue (Note 15) and $6,111,310 (March 31, 2016 – $6,056,411) related to expended deferred capital revenue (Note 16).

Contingent liabilities in which AHS has been jointly named with other government entities within the GOA are disclosed in Note 20.

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Note 22 Government Partnerships

The following is 100% of the financial position and results of operations for AHS' government partnerships.

	2017	2016
Financial assets	$ 57,950	$ 122,784
Liabilities	57,950	122,784
Accumulated surplus	$ -	$ -
Total revenues	$ 231,097	$ 229,955
Total expenses	231,097	229,955
Annual surplus	**$ -**	**$ -**

AHS has proportionately consolidated 50% of the results of the PCNs and NACTRC.

Note 23 Trusts under Administration

(a) Health Benefit Trust of Alberta (HBTA)

AHS is one of more than 30 participants in the HBTA and has a majority of representation on the HBTA governance board. The HBTA is a formal health and welfare trust established under a Trust Agreement effective January 1, 2000. The HBTA provides health and other related employee benefits pursuant to the authorizing Trust Agreement.

The HBTA maintains various reserves to adequately provide for all current obligations and reported fund balances of $78,183 as at December 31, 2016 (December 31, 2015 – $97,502). AHS has included in prepaid expenses $64,317 (March 31, 2016 – $71,664) as a share of the HBTA's fund balances representing in substance a prepayment of future premiums. These consolidated financial statements do not include the HBTA other than the premiums paid by AHS. For the fiscal year ended March 31, 2017, AHS paid premiums of $340,947 (2016 – $315,103).

(b) Other Trust Funds

AHS receives funds in trust for research and development, education, and other programs. These amounts are held and administered on behalf of others in accordance with the terms and conditions embodied in the relevant agreements with no unilateral power to change the conditions set out in the trust indenture (or agreement) and therefore are not reported in these consolidated financial statements. As at March 31, 2017, the balance of funds held in trust by AHS for research and development is $514 (March 31, 2016 – $3,762).

AHS receives funds in trust from continuing care residents for personal expenses. As at March 31, 2017, the balance of these funds is $1,717 (March 31, 2016 – $1,780). These amounts are not included in the consolidated financial statements.

Note 24 Corresponding Amounts

Certain amounts have been reclassified to conform to 2017 presentation.

Note 25 Approval of Consolidated Financial Statements

The consolidated financial statements were approved by the AHS Board on June 1, 2017.

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SCHEDULE 1 – CONSOLIDATED SCHEDULE OF EXPENSES BY OBJECT
YEAR ENDED MARCH 31

	2017		2016
	Budget (Note 3)	Actual	Actual
Salaries and benefits (Schedule 2)	$ 7,760,000	$ 7,983,182	$ 7,741,667
Contracts with health service providers	2,635,000	2,539,854	2,451,216
Contracts under the Health Care Protection Act	18,000	20,198	19,300
Drugs and gases	425,000	449,620	417,110
Medical and surgical supplies	390,000	385,213	414,053
Other contracted services	1,173,000	1,106,722	1,134,353
Other[a]	1,330,000	1,367,628	1,333,313
Amortization and disposals of tangible capital assets (Note 18)	587,000	551,015	588,851
	$ 14,318,000	**$ 14,403,432**	**$ 14,099,863**
(a) Significant amounts included in Other are:			
Equipment expense		$ 223,364	$ 208,119
Other clinical supplies		152,312	149,183
Building rent		132,080	126,825
Building and ground expenses		121,044	107,011
Utilities		105,159	107,608
Housekeeping, laundry and linen, plant maintenance and biomedical engineering supplies		90,259	87,497
Food and dietary supplies		81,985	80,078
Office supplies		54,040	58,506
Fundraising and grants awarded		50,859	54,426
Insurance and liability claims		49,639	24,199
Minor equipment purchases		45,831	69,436
Travel		41,734	39,462
Telecommunications		39,397	42,070
Licenses, fees and memberships		28,477	24,803
Education		12,107	13,628
Other		139,341	140,462
		$ 1,367,628	**$ 1,333,313**

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SCHEDULE 2 - CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS
FOR THE YEAR ENDED MARCH 31, 2017

	2017								2016	
						Severance [h]				
	FTE [a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Number of Individuals	Amount	Total	FTE [a]	Total
Total Board (Sub-Schedule 2A)	9.21	$ -	$ 310	$ -	$ 310	-	$ -	$ 310	4.42	$ 147
Total Former Official Administrator / Former Advisory Committees	-	-	-	-	-	-	-	-	4.62	248
Total Executive (Sub-Schedule 2B)	13.86	4,927	34	961	5,922	1	219	6,141	14.38	6,566
Management Reporting to CEO Direct Reports	66.06	15,176	364	2,937	18,477	2	214	18,691	54.81	15,598
Other Management	2,985.79	355,981	3,893	85,522	445,396	18	1,314	446,710	2,971.65	440,242
Medical Doctors not included above [f]	150.06	46,937	380	3,672	50,989	-	-	50,989	156.89	53,126
Regulated nurses not included above										
RNs, Reg. Psych. Nurses, Grad Nurses	18,966.63	1,807,350	248,976	405,990	2,462,316	2	88	2,462,404	18,773.62	2,386,246
LPNs	4,836.11	315,465	34,991	72,503	422,959	-	-	422,959	4,691.76	417,040
Other Health Technical & Professional	16,307.58	1,458,289	83,499	338,966	1,880,754	7	60	1,880,814	15,964.01	1,824,007
Unregulated Health Service Providers	8,716.34	442,343	43,373	107,204	592,920	3	35	592,955	8,542.13	585,336
Other Staff	26,382.57	1,667,727	55,831	376,998	2,100,556	37	653	2,101,209	25,829.17	2,013,111
Total	**78,434.21**	**$ 6,114,195**	**$ 471,651**	**$ 1,394,753**	**$ 7,980,599**	**70**	**$ 2,583**	**$ 7,983,182**	**77,007.46**	**$ 7,741,667**

The accompanying footnotes and sub-schedules are part of this schedule.

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SUB-SCHEDULE 2A – BOARD REMUNERATION FOR THE YEAR ENDED MARCH 31, 2017

	Term	2017 Committees	2017 Remuneration	2016 Remuneration
Board Chair				
Linda Hughes[1]	Since Nov 27, 2015	ARC, CEC, FC, GC, HRC, QSC	$ 71	$ 26
Board Members				
Dr. Brenda Hemmelgarn (Vice Chair)	Since Nov 27, 2015	CEC (Chair), QSC	51	19
David Carpenter	Since Nov 27, 2015	ARC (Chair), CEC, FC (Chair)	38	14
Richard Dicerni[1]	Since Nov 27, 2015	FC, HRC (Chair)	30	-
Heather Hirsch	Since Nov 3, 2016	CEC, QSC	9	-
Hugh Sommerville	Since Nov 27, 2015	ARC, GC (Chair)	37	13
Marliss Taylor	Since Nov 27, 2015	CEC, GC, HRC	36	12
Glenda Yeates	Since Nov 27, 2015	ARC, FC, QSC (Chair)	33	13
Board Committee Participants[2]				
Barbara Burton	Nov 27, 2015 to Mar 31, 2016	-	-	12
Dr. Thomas Feasby	Nov 27, 2015 to Jan 18, 2017	QSC	2	2
Martin Harvey	Nov 27, 2015 to Mar 31, 2016	-	-	1
Don Sieben	Nov 27, 2015 to Mar 31, 2016	-	-	17
Doug Tupper	Nov 27, 2015 to Mar 31, 2016	-	-	17
Gord Winkel	Since Nov 27, 2015	QSC	3	1
Total Board			**$ 310**	**$ 147**

Board members were remunerated with monthly honoraria. In addition, they receive remuneration for attendance at Board and committee meetings.

Board committees were established by the Board to assist in governing AHS and overseeing the management of AHS' business and affairs. Board committee participants are eligible to receive remuneration for meetings attended, and in addition Board committee chairs also receive a monthly honorarium.

Committee legend: ARC = Audit and Risk Committee, CEC = Community Engagement Committee, FC = Finance Committee, GC = Governance Committee, HRC = Human Resources Committee, QSC = Quality and Safety Committee

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SUB-SCHEDULE 2B - EXECUTIVE SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2017

For the Current Fiscal Year	2017						
	FTE [a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance [e]	Total
Board Direct Reports							
Dr. Verna Yiu – President and Chief Executive Officer[g, m]	1.00	$ 565	$ 16	$ 163	$ 744	$ -	$ 744
Ronda White – Chief Audit Executive [m]	1.00	240	-	39	279	-	279
CEO Direct Reports							
Brenda Huband – VP and Chief Health Operations Officer, Central and Southern Alberta[k, m]	1.00	370	-	44	414	-	414
Dr. Ted Braun – VP and Medical Director, Central and Southern Alberta[l, m]	1.00	383	5	69	457	-	457
Deb Gordon – VP and Chief Health Operations Officer, Northern Alberta[m]	1.00	370	-	104	474	-	474
Dr. David Mador – VP and Medical Director, Northern Alberta[n]	1.00	450	-	104	554	-	554
Sean Chilton – VP, Collaborative Practice, Nursing and Health Professions[m, o]	0.27	89	-	14	103	-	103
Dave Bilan – Interim VP, Collaborative Practice, Nursing and Health Professions[m]	0.77	130	-	2	132	-	132
Dr. Francois Belanger – VP, Quality and Chief Medical Officer[p, m]	1.00	456	-	93	549	-	549
Karen Horon – Acting VP, Clinical Support Services[p, m]	0.02	5	-	1	6	-	6
Mauro Chies – VP, Clinical Support Services[q, m]	0.80	245	-	40	285	-	285
Dr. Kathryn Todd – VP, Research, Innovation and Analytics[r, s]	1.00	264	13	32	309	-	309
Todd Gilchrist – VP, People, Legal and Privacy[m]	1.00	450	-	78	528	-	528
Colleen Turner – VP, Community Engagement and Communications[s, m]	1.00	314	-	81	395	-	395
Deborah Rhodes – VP, Corporate Services and Chief Financial Officer[m]	1.00	370	-	65	435	-	435
Noela Inions – Chief Ethics and Compliance Officer[t]	1.00	226	-	32	258	219	477
Total Executive	**13.86**	**$ 4,927**	**$ 34**	**$ 961**	**$ 5,922**	**$ 219**	**$ 6,141**

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SUB-SCHEDULE 2B - EXECUTIVE SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2017 (CONTINUED)

	2016						
For the Prior Fiscal Year	FTE [a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance [e]	Total
Board / Official Administrator Direct Reports							
Dr. Verna Yiu – Interim President and Chief Executive Officer	0.23	$ 120	$ 22	$ 8	$ 150	$ -	$ 150
Vickie Kaminski – President and Chief Executive Officer	0.85	462	31	32	525	-	525
Ronda White – Chief Audit Executive	1.00	241	-	36	277	-	277
CEO Direct Reports							
Brenda Huband – VP and Chief Health Operations Officer, Central and Southern Alberta	1.00	372	-	50	422	-	422
Dr. Ted Braun – Acting VP and Medical Director, Central and Southern Alberta	0.23	88	1	13	102	-	102
Dr. Francois Belanger – VP and Medical Director, Central and Southern Alberta	0.77	348	-	66	414	-	414
Deb Gordon – VP and Chief Health Operations Officer, Northern Alberta	1.00	372	-	32	404	-	404
Dr. David Mador – VP and Medical Director, Northern Alberta	1.00	452	-	70	522	-	522
Dave Bilan – Interim VP Collaborative Practice, Nursing and Health Professions	0.34	57	-	9	66	-	66
Linda Dempster – VP Collaborative Practice, Nursing and Health Professions	0.66	172	-	23	195	-	195
Dr. Francois Belanger – Interim VP, Quality and Chief Medical Officer	0.23	104	-	20	124	-	124
Dr. Verna Yiu – VP, Quality and Chief Medical Officer	0.77	402	36	26	464	-	464
Dr. Kathryn Todd – VP, Research, Innovation and Analytics	1.00	264	15	29	308	-	308
Todd Gilchrist – VP, Human Resources	0.91	406	-	123	529	-	529
Robert Armstrong – Acting VP, Human Resources	0.09	22	3	6	31	-	31
Colleen Turner – Interim VP, Community Engagement and Communications	0.23	61	-	13	74	-	74
Carmel Turpin – VP, Community Engagement and Communications	0.78	237	-	30	267	293	560
Deborah Rhodes – VP, Corporate Services and Chief Financial Officer	1.00	372	-	48	420	-	420
Noela Inions – Chief Ethics and Compliance Officer	1.00	227	-	45	272	-	272
Vivian Simpkin – Interim General Counsel, Legal and Privacy	0.22	48	5	9	62	-	62
Salimah Walji-Shivji – General Counsel, Legal and Privacy	0.46	111	-	21	132	266	398
Sharon Lehr – Chief Program Officer, Operational Benchmarking and Efficiency	0.61	188	-	59	247	-	247
Total Executive	**14.38**	**$ 5,126**	**$ 113**	**$ 768**	**$ 6,007**	**$ 559**	**$ 6,566**

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SUB-SCHEDULE 2C - EXECUTIVE SUPPLEMENTAL PENSION PLAN AND SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN

Certain employees will receive retirement benefits that supplement the benefits limited under the registered plans for service. The Supplemental Pension Plan (SPP) is a defined contribution plan and the Supplemental Executive Retirement Plan (SERP) is a defined benefit plan. The SERP is disclosed in Note 2(h)(iii). The amounts in this table represent the total SPP and SERP benefits earned by the individual during the fiscal year. The current period benefit costs for SPP and the other costs for SERP included in other non-cash benefits disclosed in Sub-Schedule 2B are prorated for the period of time the individual was in their position directly reporting to the Board or directly reporting to the President and Chief Executive Officer. Only individuals holding a position directly reporting to the Board or President and Chief Executive Officer during the current fiscal year are disclosed.

	2017			2016			
	SPP	SERP					
	Current period benefit costs[1]	Other Costs[2]	Total	Total	Account Balance[3] or Accrued Benefit Obligation March 31, 2016	Change During the Year[4]	Account Balance[3] or Accrued Benefit Obligation March 31, 2017
Dr. Verna Yiu - President and Chief Executive Officer	$ 41	$ -	$ 41	$ -	$ -	$ 41	$ 41
Ronda White - Chief Audit Executive	9	-	9	10	51	12	63
Brenda Huband - VP and Chief Health Operations Officer, Central and Southern Alberta							
SERP	-	23	23	(8)	422	(42)	380
SPP	25	-	25	25	95	30	125
Dr. Ted Braun - VP and Medical Director, Central and Southern Alberta							
SERP	-	12	12	(4)	217	(8)	209
SPP	27	-	27	16	58	27	85
Deb Gordon - VP and Chief Health Operations Officer, Northern Alberta							
SERP	-	35	35	(11)	626	23	649
SPP	25	-	25	25	85	31	116
Dr. David Mador - VP and Medical Director, Northern Alberta	35	-	35	35	106	38	144
Sean Chilton - VP, Collaborative Practice, Nursing and Health Professions	18	-	18	18	94	21	115
Dr. Francois Belanger - VP, Quality and Chief Medical Officer	35	-	35	35	127	45	172
Karen Horon - Acting VP, Clinical Support Services	4	-	4	4	12	4	16
Mauro Chies - VP, Clinical Support Services	16	-	16	12	49	18	67
Dr. Kathryn Todd - VP, Research, Innovation and Analytics [5]	-	-	-	-	-	-	-
Todd Gilchrist - VP, People, Legal and Privacy	35	-	35	31	31	36	67
Colleen Turner - VP, Community Engagement and Communications	18	-	18	10	48	22	70

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SUB-SCHEDULE 2C - EXECUTIVE SUPPLEMENTAL PENSION PLAN AND SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN (CONTINUED)

	2017			2016			
	SPP	SERP					
	Current period benefit costs[1]	Other Costs[2]	Total	Total	Account Balance[3] or Accrued Benefit Obligation March 31, 2016	Change During the Year[4]	Account Balance[3] or Accrued Benefit Obligation March 31, 2017
Deborah Rhodes - VP, Corporate Services and Chief Financial Officer	$ 25	$ -	$ 25	$ 25	$ 138	$ 32	$ 170
Noela Inions - Chief Ethics and Compliance Officer	8	-	8	8	64	12	76

(1) The SPP current period benefit costs are AHS contributions earned in the period.
(2) Other SERP costs include retirement benefits, interest expense on the obligations, and amortization of actuarial gains and losses, offset by the expected return on the plans' assets. AHS uses the straight line method to amortize actuarial gains and losses over the expected average remaining service life of the plan members.
(3) The account balance represents the total cumulative earned contributions to the SPP as well as cumulative investment gains or losses on the contributions.
(4) Changes in the accrued benefit obligation include current period benefit cost, interest accruing on the obligations and the amortization of any actuarial gains or losses in the period. Changes in the account balance include the current benefit costs and investment gains or losses related to the account.

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FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2017

Definitions

a. For this schedule, full time equivalents (FTE) are determined by actual hours earned divided by 2,022.75 annual base hours. FTE for the Board and Board committee members are prorated using the number of days in the fiscal year between either the date of appointment and the end of the year, the date of appointment and the termination date, or the beginning of the year and the termination date.

b. Base salary is regular salary and includes all payments earned related to actual hours earned other than those reported as other cash benefits.

Vacation accruals are included in base salary except for direct reports of the Board or President and Chief Executive Officer whose vacation accruals are included in other non-cash benefits.

c. Other cash benefits include, as applicable, honoraria, overtime, acting pay, travel and automobile allowances, lump sum payments and an allowance for professional development. Relocation expenses are excluded from compensation disclosure as they are considered to be recruiting costs to AHS and not part of compensation unless related to severance. Expense reimbursements are also excluded from compensation disclosure except where the expenses meet the definition of the other cash benefits listed above.

d. Other non-cash benefits include:
- Employer's current period benefit costs and other costs of supplemental pension plan and supplemental executive retirement plans as defined in Sub-Schedule 2C.
- Employer's share of employee benefit contributions and payments made on behalf of employees including pension, health care, dental and vision coverage, out-of-country medical benefits, group life insurance, accidental disability and dismemberment insurance, and long and short-term disability plans, and
- Employer's share of the cost of additional benefits including sabbaticals or other special leave with pay.

e. Severance includes direct or indirect payments to individuals upon termination which are not included in other cash benefits or other non-cash benefits.

f. Compensation provided by AHS for medical doctors included in salaries and benefits expense includes medical doctors paid through AHS payroll. The compensation provided by AHS for the remaining medical doctors is included in other contracted services.

Board and Board Committee Participants

g. The Board Chair is an Ex-Officio member on all committees.

h. This individual started claiming honoraria on April 16, 2016.

i. These individuals were participants of Board committees, but are not Board members or AHS employees.

Executive

j. The incumbent held the position of Interim President and Chief Executive Officer and received acting pay until June 3, 2016 when the incumbent was appointed to President and Chief Executive Officer. The incumbent received an increase in compensation for the new position. The contract term ends June 2, 2021. The incumbent was on secondment from the University of Alberta until June 3, 2016. During this time, the incumbent's total remuneration was comprised of salary amounts from both AHS and the University of Alberta, and AHS reimbursed the University for the incumbent's base salary and benefits. In lieu of enrollment into the AHS SPP, the incumbent received an annual lump sum supplemental payment equivalent to the amount the incumbent would have received as a member of the SPP and payable from AHS. The lump sum has been included in Other Cash Benefits. Effective June 3, 2016, the incumbent began a leave of absence from the University of Alberta and entered into an employment relationship with AHS.

k. The incumbent received a vacation payout of $29 during the year for unused accrued vacation earned in prior periods; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

l. The incumbent held the position of Acting Vice President and Medical Director, Central and Southern Alberta and received an increase in base salary until February 13, 2017 at which time the incumbent was appointed to Vice President and Medical Director, Central and Southern Alberta. The incumbent received an increase in compensation for the new position.

m. The incumbent held the position of Chief Zone Officer, South Zone until December 26, 2016 at which time the incumbent was appointed to Vice President, Collaborative Practice, Nursing and Health Professions and became a direct report to the President and Chief Executive Officer. The incumbent received an increase in compensation for the new position.

n. The incumbent held the position of Interim Vice President, Collaborative Practice, Nursing and Health Professions and received an increase in base salary until January 9, 2017 at which time the incumbent resumed the role of Executive Director, Health Professions – Strategy and Practice and is no longer a direct report to the President and Chief Executive Officer.

o. The incumbent held the position of Interim Vice President, Quality and Chief Medical Officer until November 1, 2016 when the incumbent was appointed to Vice President, Quality and Chief Medical Officer. The incumbent received an increase in compensation for the new position.

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FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2017 (CONTINUED)

p. The incumbent held the position of Senior Operating Officer, Pharmacy Services until March 28, 2017 at which time the incumbent was appointed to Acting Vice President, Clinical Support Services and became a direct report to the President and Chief Executive Officer. The incumbent received an increase in base salary for the Acting Vice President, Clinical Support Services position.

q. The incumbent held the position of Chief Program Officer, Clinical Support Services until June 13, 2016 at which time the incumbent was appointed to Vice President, Clinical Support Services and became a direct report to the President and Chief Executive Officer. The incumbent received an increase in compensation for the new position. In addition, the incumbent received a vacation payout of $6 during the year for unused accrued vacation earned in prior periods, accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned. The incumbent began a leave of absence on March 28, 2017.

r. The incumbent is on secondment from the University of Alberta. The incumbent's total remuneration is comprised of salary amounts from both AHS and the University of Alberta, and AHS reimburses the University for the incumbent's base salary and benefits. In lieu of enrollment into the AHS SPP, the incumbent will receive an annual lump sum supplemental payment equivalent to the amount the incumbent would have received as a member of the SPP and payable from AHS. The lump sum has been included in Other Cash Benefits.

s. The incumbent held the position of Interim Vice President, Community Engagement and Communications and received an increase in base salary until July 4, 2016 when the incumbent was appointed to Vice President, Community Engagement and Communications. The incumbent received an increase in compensation for the new position.

t. The incumbent held the position until April 21, 2017, at which time the accountability and scope of the position was expanded. The employer and employee negotiated a separation agreement which resulted in the incumbent resigning her position in exchange for a severance payment. The employer allowed this resignation to be communicated as a retirement. The incumbent received salary and other accrued entitlements to the date of resignation. The reported severance included 44 weeks of base salary at the rate in effect at the date of retirement and an additional 15% of the severance in lieu of benefits. This severance was expensed in the current year.

Termination Obligations

u. In the case of termination without just cause by AHS, the incumbent shall receive severance pay equal to one month base salary for each completed month of service during the first year of the term or, after completion of one year of service of the term, 12 months base salary.

v. In the case of termination without just cause by AHS, the incumbent shall receive severance pay equal to 12 months base salary. The severance payment will be reduced by any employment earnings received from a new employer within the 12 month period.

w. The incumbent's termination benefits have not been predetermined.

x. In the case of termination without just cause by AHS, the incumbent shall receive severance pay to a maximum of 12 months base salary plus market supplement. Such severance will be paid in 12 equal monthly instalments. The severance payment will be reduced by any employment earnings received from a new employer within the 12 month period.

y. There is no severance associated with the secondment agreement. Upon termination of the secondment agreement, the incumbent would return to the incumbent's regular position at the University of Alberta.

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FINANCIAL INFORMATION
Health Quality Council of Alberta

Financial Statements
March 31, 2017

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HEALTH QUALITY COUNCIL OF ALBERTA

FINANCIAL STATEMENTS

YEAR ENDED MARCH 31, 2017

HQCA Management's Responsibility

Independent Auditor's Report

Statement of Operations

Statement of Financial Position

Statement of Change in Net Financial Assets

Statement of Cash Flows

Notes to the Financial Statements

Schedule 1 – Expenses – Detailed by Object

Schedule 2 – Salary and Benefits Disclosure

Scedule 3 – Related Party Transactions

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HEALTH QUALITY COUNCIL OF ALBERTA
MANAGEMENT'S RESPONSIBILITY FOR THE FINANCIAL STATEMENTS
MARCH 31, 2017

The accompanying financial statements are the responsibility of management and have been reviewed and approved by Senior Management. The financial statements were prepared in accordance with Canadian Public Sector Accounting Standards, and of necessity, include some amounts that are based on estimates and judgement.

To discharge its responsibility for the integrity and objectivity of financial reporting, management maintains a system of internal accounting controls comprising written policies, standards and procedures, a formal authorization structure, and satisfactory processes for reviewing internal controls. This system provides management with reasonable assurance that transactions are in accordance with governing legislation and are properly authorized, reliable financial records are maintained, and assets are adequately safeguarded.

The Health Quality Council of Alberta's Board of Directors carries out their responsibility for the financial statements through the Audit and Finance Committee. The Committee meets with management and the Auditor General of Alberta to review financial matters, and recommends the financial statements to the Health Quality Council of Alberta Board of Directors for approval upon finalization of the audit. The Auditor General of Alberta has open and complete access to the Audit and Finance Committee.

The Auditor General of Alberta provides an independent audit of the financial statements. His examination is conducted in accordance with Canadian Generally Accepted Auditing Standards and includes tests and procedures, which allow him to report on the fairness of the financial statements prepared by management.

On behalf of the Health Quality Council of Alberta.

[Original signed by Andrew Neuner]

Chief Executive Officer
Andrew Neuner
May 31, 2017

[Original signed by Jessica Wing]

Director, Financial Services
Jessica Wing
May 31, 2017

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AUDITOR GENERAL *Alberta*

Independent Auditor's Report

To the Board of Directors of the Health Quality Council of Alberta

Report on the Financial Statements

I have audited the accompanying financial statements of the Health Quality Council of Alberta, which comprise the statement of financial position as at March 31, 2017, and the statements of operations, change in net financial assets and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on these financial statements based on my audit. I conducted my audit in accordance with Canadian generally accepted auditing standards. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

In my opinion, the financial statements present fairly, in all material respects, the financial position of the Health Quality Council of Alberta as at March 31, 2017, and the results of its operations, its remeasurement gains and losses, its changes in net financial assets, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

[Original signed by Merwan N. Saher FCPA, FCA]

Auditor General

May 31, 2017

Edmonton, Alberta

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HEALTH QUALITY COUNCIL OF ALBERTA
STATEMENT OF OPERATIONS
Year ended March 31

	2017		2016
	Budget	Actual	Actual
	(in thousands)		
Revenues			
Government transfers			
Alberta Health - operating grant	$ 6,611	$ 6,946	$ 6,611
Investment income	10	6	9
Other revenue	77	43	26
	6,698	6,995	6,646
Expenses			
Administration	2,552	2,688	2,838
Survey, measure and monitor initiatives	2,686	2,289	2,257
Patient safety initiatives	1,245	1,186	1,038
Quality initiatives	857	734	707
Communication	409	391	402
Ministerial assessment/study	-	239	109
	7,749	7,527	7,351
Annual operating surplus (deficit)	(1,051)	(532)	(705)
Accumulated operating surplus, beginning of year		1,890	2,595
Accumulated operating surplus, end of year	$	$ 1,358	$ 1,890

The accompanying notes and schedules are part of these financial statements.

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HEALTH QUALITY COUNCIL OF ALBERTA
STATEMENT OF FINANCIAL POSITION
As at March 31

	2017	2016
	(in thousands)	
Financial Assets		
Cash	$ 1,008	$ 1,579
Accounts receivable	44	47
	1,052	1,626
Liabilities		
Accounts payable and accrued liabilities	727	844
Employee future benefits (Note 6)	68	43
Deferred revenue (Note 7)	-	7
Deferred lease inducements (Note 8)	53	81
	848	975
Net Financial Assets	204	651
Non-Financial Assets		
Tangible capital assets (Note 9)	1,081	1,186
Prepaid expenses	73	53
	1,154	1,239
Net Assets	1,358	1,890
Net Assets		
Accumulated operating surplus (Note 11)	$ 1,358	$ 1,890

Contractual obligations (Note 10)

The accompanying notes and schedules are part of these financial statements.

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HEALTH QUALITY COUNCIL OF ALBERTA
STATEMENT OF CHANGE IN NET FINANCIAL ASSETS
Year ended March 31

	2017		2016
	Budget	Actual	Actual
		(in thousands)	
Annual operating (deficit) surplus	$ (1,051)	$ (532)	$ (705)
Acquisition of tangible capital assets (Note 9)	(30)	(77)	(217)
Amortization of tangible capital assets (Note 9)	136	182	168
Change in prepaid expenses		(20)	(14)
(Decrease) in net financial assets in the year		(447)	(768)
Net financial assets, beginning of year		651	1,419
Net financial assets, end of year	$	$ 204	$ 651

The accompanying notes and schedules are part of these financial statements.

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HEALTH QUALITY COUNCIL OF ALBERTA
STATEMENT OF CASH FLOWS
Year ended March 31

	2017	2016
	(in thousands)	
Operating Transactions		
Annual operating (deficit) surplus	$ (532)	$ (705)
Non-cash items:		
Amortization of tangible capital assets (Note 9)	182	168
Amortization of tenant inducements (Note 8)	(47)	(47)
Increase in employee future benefits (Note 6)	25	26
	(372)	(558)
Decrease in accounts receivable	3	62
(Increase) in prepaid expenses	(20)	(14)
(Decrease) Increase in accounts payable and accrued liabilities	(117)	10
(Decrease) Increase in deferred revenue	(7)	7
Increase in deferred lease inducements	19	18
Cash (applied to) operating transactions	(494)	(475)
Capital Transactions		
Acquisition of tangible capital assets	(77)	(217)
Cash (applied to) capital transactions	(77)	(217)
(Decrease) in cash	(571)	(692)
Cash at beginning of year	1,579	2,271
Cash at end of year	$ 1,008	$ 1,579

The accompanying notes and schedules are part of these financial statements.

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Note 1 AUTHORITY

The Health Quality Council of Alberta (HQCA) is a corporation under the Health Quality Council of Alberta Act and a government not-for-profit organization.

Pursuant to the Health Quality Council of Alberta Act, the HQCA has a mandate to promote and improve patient safety and health service quality on a province-wide basis.

The Health Quality Council of Alberta is exempt from income taxes under the Income Tax Act.

Note 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND REPORTING PRACTICES

These financial statements are prepared in accordance with Canadian Public Sector Accounting Standards (PSAS).

(a) Reporting Entity

The financial statements reflect the assets, liabilities, revenues and expenses of the HQCA.

(b) Basis of Financial Reporting

Revenues

All revenues are reported on the accrual basis of accounting. Cash received, for which services have not been provided by year end is recognized as deferred revenue.

Government transfers

Transfers from all governments are referred to as government transfers.

Government transfers and the associated externally restricted investment income are recognized as deferred revenue if the eligibility criteria for use of the transfer, or the stipulations together with the HQCA's actions and communications as to the use of the transfer, create a liability. These transfers are recognized as revenue as the stipulations are met and, when applicable, the HQCA complies with its communicated use of these transfers.

All other government transfers, without stipulations for the use of the transfer, are recognized as revenue when the transfer is authorized and the HQCA meets the eligibility criteria (if any).

Expenses

Expenses are reported on an accrual basis. The cost of all goods consumed and services received during the year are expensed.

Grant and transfers are recognized as expenses when the transfer is authorized and eligibility criteria, if any, have been met by the recipient.

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Note 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND REPORTING PRACTICES (CONT'D)

(b) Basis of Financial Reporting (Cont'd)

Valuation of Financial Assets and Liabilities

The HQCA's financial assets and liabilities are generally measured as follows:

Financial Statement Component	Measurement
Cash	Cost
Accounts receivable	Lower of cost or net recoverable value
Accounts payable and accrued liabilities	Cost

The HQCA does not hold equities traded in an active market, nor engage in derivative contracts or foreign currency transactions. The HQCA is not exposed to remeasurement gains or losses and, consequently, a statement of remeasurement gains and losses is not presented.

Financial Assets

Financial assets are the HQCA's financial claims on external organizations and individuals at the year end.

Cash

Cash comprises cash on hand and demand deposits.

Accounts Receivable

Accounts receivable are recognized at the lower of cost or net recoverable value. A valuation allowance is recognized when recovery is uncertain.

Liabilities

Liabilities represent present obligations of the HQCA to external organizations and individuals arising from transactions or events occurring before the year end. They are recognized when there is an appropriate basis of measurement and management can reasonably estimate the amount.

Liabilities also include:

- All financial claims payable by the HQCA at year end;
- Accrued employee vacation entitlements; and
- Contingent liabilities where future liabilities are likely.

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Note 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND REPORTING PRACTICES (CONT'D)

(b) Basis of Financial Reporting (Cont'd)

Deferred Tenant Inducements

Deferred tenant inducements represent amounts received for leasehold improvements and the value of a rent-free period. Lease inducements are deferred and amortized on a straight-line basis over the term of the related lease and the amortization is recognized as a reduction of rent expense for the year.

Employee Future Benefits

The HQCA Board has approved a defined contribution Supplementary Executive Retirement Plan (SERP) for certain members of its executive staff. The SERP supplements the benefit under the HQCA registered plan that is limited by the *Income Tax Act* (Canada). The HQCA contributes a certain percentage of an eligible employee's pensionable earnings in excess of the limits of the *Income Tax Act* (Canada). This plan provides participants with an account balance at retirement based on the contributions made to the plan and investment income earned on the contributions based on investment decisions made by the participants.

Non-Financial Assets

Non-financial assets are limited to tangible capital assets and prepaid expenses.

Tangible Capital Assets

Tangible capital assets are recognized at cost, which includes amounts that are directly related to the acquisition, design, construction, development, improvement or betterment of the assets. Cost includes overhead directly attributable to construction and development, as well as interest costs that are directly attributable to the acquisition or construction of the asset.

The cost, less residual value, of the tangible capital assets, excluding work-in-progress, is amortized on a straight-line basis over their estimated useful lives as follows:

Computer hardware and software	5 years
Office equipment	10 years
Leasehold improvements	Over term of lease

Tangible capital assets are written down when conditions indicate that they no longer contribute to the HQCA's ability to provide services, or when the value of future economic benefits associated with the tangible capital assets are less than their book value. The net write-downs are accounted for as expenses in the Statement of Operations.

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Note 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND REPORTING PRACTICES (CONT'D)

(b) Basis of Financial Reporting (Cont'd)

Prepaid Expenses

Prepaid expenses are recognized at cost and amortized based on the terms of the agreement.

Funds and Reserves

Certain amounts, as approved by the Board of Directors, are set aside in accumulated operating surplus for future operating and capital purposes. Transfers to/from funds and reserves are an adjustment to the respective fund when approved.

Measurement Uncertainty

Measurement uncertainty exists when there is a variance between the recognized or disclosed amount and another reasonably possible amount. The amounts recognized for amortization of tangible capital assets are based on estimates of the useful life of the related assets. Actual results could differ from estimates.

Note 3 FUTURE ACCOUNTING CHANGES

The Public Sector Accounting Board issued the following accounting standards:

PS 2200 Related Party Disclosures and PS 3420 Inter-Entity Transactions (effective April 1, 2017)

PS 2200 defines a related party and establishes disclosures required for related party transactions. PS 3420 establishes standards on how to account for and report transactions between public sector entities that comprise a government's reporting entity from both a provider and recipient perspective.

PS 3210 Assets, PS 3320 Contingent Assets, and PS 3380 Contractual Rights (effective April 1, 2017)

PS3210 provides guidance for applying the definition of assets set out in FINANCIAL STATEMENT CONCEPTS, Section PS 1000, and establishes general disclosure standards for assets, PS 3320 defines and establishes disclosure standards on contingent assets; PS 3380 defines and establishes disclosure standards on contractual rights.

PS 3430 Restructuring Transactions (effective April 1, 2018)

This standard provides guidance on how to account for and report restructuring transactions by both transferors and recipients of assets and/or liabilities, together with related program or operating responsibilities.

Management is currently assessing the impact of these standards on the financial statements.

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Note 4 BUDGET

The HQCA's 2016-2017 business plan with a budgeted deficit of ($1,051) was approved by the Board of Directors on February 25, 2016. The approved financial plan was submitted to the Ministry of Health.

Note 5 FINANCIAL RISK MANAGEMENT

The HQCA has the following financial instruments: accounts receivable, accounts payable and accrued liabilities.

The HQCA has exposure to the following risks from its use of financial instruments: interest rate risk, liquidity risk, other price risk and credit risk.

(a) Interest rate risk

Interest rate risk is the risk that the rate of return and future cash flows on the HQCA's short-term investments will fluctuate because of changes in market interest rates. As the HQCA invests in short term deposits of 90 days or less and accounts payable are non-interest bearing, the HQCA is not exposed to significant interest rate risk relating to its financial instruments.

(b) Liquidity risk

Liquidity risk is the risk that the HQCA will encounter difficulty in meeting obligations associated with financial liabilities. The HQCA enters into transactions to purchase goods and services on credit. Liquidity risk is measured by reviewing the HQCA's future net cash flows for the possibility of negative net cash flow. The HQCA manages the liquidity risk resulting from its accounts payable obligations by maintaining cash resources and investing in short-term deposits of 90 days or less.

(c) Other price risk

Other price risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices (other than those arising from interest rate risk or foreign currency risk), whether those changes are caused by factors specific to the individual financial instrument or its issuer, or factors affecting all similar financial instruments traded in the market. Price risk is managed by holding short-term deposits for 90 days or less.

(d) Credit risk

The HQCA is exposed to credit risk from potential non-payment of accounts receivable. During the fiscal year most of the HQCA's receivables are from provincial agencies; therefore the credit risk is minimized.

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Note 6 BENEFIT PLAN

The HQCA participates in the Local Authorities Pension Plan (LAPP), a multi- employer defined benefit pension plan.

The HQCA accounts for this multi-employer pension plan on a defined contribution basis. The HQCA is not responsible for future funding of the plan deficit other than through contribution increases. Pension expense recorded in the financial statements is equivalent to HQCA's annual contributions of $448 for the year ended March 31, 2017 (2016 - $383).

At December 31, 2016, the Local Authorities Pension Plan reported a deficiency of $637,357 (2015 deficiency of $923,416).

The Supplementary Executive Retirement Plan (SERP) expense for the year ended March 31, 2017 is $25 (2016 - $26).

Note 7 DEFERRED REVENUE

Deferred revenue represents unspent externally restricted resources. Changes in the balance are as follows:

	2017	2016
Balance, beginning of the year	$ 7	$
Amount received	-	25
Amounts recognized in revenue	-	(18)
Amount repaid	(7)	-
Balance, end of the year	$ -	$ 7

Note 8 DEFERRED LEASE INDUCEMENTS

The HQCA received a leasehold inducement of $137 for renovations in 2015. The inducement is accounted for as a reduction of rent expense and amortized over the term of the lease.

In 2016, the HQCA received a lease inducement in the form of free rent relating to a lease renewal of the premises effective 2018. This amount will be amortized on a straight-line basis over the term of the related lease and the amortization is recognized as a reduction of rent expense for the year starting 2018.

	2017	2016
Lease inducements - renovations	$ 137	$ 137
Lease inducements - rent free periods	37	18
Less accumulated amortization	(121)	(74)
	$ 53	$ 81

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Note 9 TANGIBLE CAPITAL ASSETS

	2017				2016
	Equipment	Computer Hardware & Software	Leasehold Improvements	Total	Total
Estimated useful life	10 yrs	5 yrs	5-10 yrs		
Historical Cost					
Beginning of year	$ 365	$ 422	$ 1,008	$ 1,795	$ 1,578
Additions	36	36	5	77	217
Disposals, including write-downs	-	(101)	-	(101)	-
	401	357	1,013	1,771	1,795
Accumulated Amortization					
Beginning of year	121	334	154	609	441
Amortization expense	32	28	122	182	168
Effect of disposals, including write-downs	-	(101)	-	(101)	-
	153	261	276	690	609
Net book value at March 31, 2017	$ 248	$ 96	$ 737	$ 1,081	
Net book value at March 31, 2016	$ 244	$ 88	$ 854		$ 1,186

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Note 10 CONTRACTUAL OBLIGATIONS

Contractual obligations are obligations of the HQCA to others that will become liabilities in the future when the terms of those contracts or agreements are met.

Estimated payment requirements for each of the next five years and thereafter are as follows:

Year ended March 31	Total lease payments
2017 - 18	$ 378
2018 – 19	394
2019 - 20	489
2020 - 21	502
2021 - 22	506
Thereafter	507
	$ 2,776

Note 11 ACCUMULATED OPERATING SURPLUS

Accumulated operating surplus is comprised of the following:

	Investment in Tangible Capital Assets[(a)]	Internally Restricted Surplus[(b)]	Unrestricted Surplus (Deficit)	Total	2016
Balance, April 1, 2016	$ 1,043	$ 847	$ -	$ 1,890	$ 2,595
Annual operating (deficit)	-	-	(532)	(532)	(705)
Net investments in capital assets	22	-	(22)	-	-
Transfers	-	(554)	554	-	-
Balance, March 31, 2017	$ 1,065	$ 293	$ -	$ 1,358	$ 1,890

(a) Net assets equal to net book value of internally funded tangible capital assets are restricted as these net assets are not available for any other purpose.

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Note 12 ACCUMULATED OPERATING SURPLUS (CONT'D)

(b) The internally restricted surplus represents amounts set aside by the Board for future purposes. Those amounts are not available for other purposes without the approval of the Board. Internally restricted surplus is summarized as follows:

	2017	2016
Build capacity	$ 35	$ 132
Measure to improve	258	465
Monitor the health system	-	250
	$ 293	$ 847

Note 13 COMPARATIVE FIGURES

Certain 2016 figures have been reclassified to conform to the 2017 presentation.

Note 14 APPROVAL OF THE FINANCIAL STATEMENTS

The financial statements were approved by the HQCA Board of Directors on May 31, 2017.

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HEALTH QUALITY COUNCIL OF ALBERTA
SCHEDULE 1 – EXPENSES – DETAILED BY OBJECT
Year ended March 31

	2017		2016
	Budget	Actual	Actual
	(in thousands)		
Salaries and benefits	$ 4,736	$ 4,539	$ 4,210
Supplies, services and other [1]	2,877	2,806	2,973
Amortization of tangible capital assets	136	182	168
	$ 7,749	$ 7,527	$ 7,351

(1) Supplies, services and other include the Patient Experience Awards of $10 (2016 nil) to recognize and celebrate initiatives that improve the patient experience in accessing and receiving healthcare services.

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HEALTH QUALITY COUNCIL OF ALBERTA
SCHEDULE 2 – SALARY AND BENEFITS DISCLOSURE
Year ended March 31

	2017				2016
	Base Salary [1]	Other Cash Benefits [2]	Other Non-Cash Benefits [3]	Total	Total
	(in thousands)				
Board of Directors-Chair	$ -	$ 16	$ -	$ 16	$ 12
Board of Directors-Members	-	37	-	37	35
Chief Executive Officer	350	-	56	406	406
Executive Director	184	-	37	221	219
	$ 534	$ 53	$ 93	$ 680	$ 672

(1) Base salary includes pensionable base pay.

(2) Other cash benefits include honoraria for board members.

(3) Other non-cash benefits include: employer's portion of all employee benefits and contributions or payments made on behalf of employees, including pension, Supplementary Executive Retirement Plan, health care, dental coverage, vision coverage, out of country medical benefits, group life insurance, accidental disability and dismemberment insurance, long and short-term disability plans, employee assistance program, employment insurance and parking.

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HEALTH QUALITY COUNCIL OF ALBERTA
SCHEDULE 3 – RELATED PARTY TRANSACTIONS
Year ended March 31

Related parties are those entities consolidated or accounted for on a modified equity basis in the Government of Alberta's financial statements.

The HQCA had the following transactions with related parties recorded in the Statements of Operations and the Statements of Financial Position at the amount of consideration agreed upon between the related parties.

	2017	2016
	(in thousands)	
Revenues		
Grants	$ 6,946	$ 6,611
Other	13	-
	$ 6,959	$ 6,611
Expenses		
Other services	$ 264	$ 465
Grants	-	30
	$ 264	$ 495
Receivable from related parties	$ -	$ -
Payable to related parties	$ 35	$ 76

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OTHER FINANCIAL INFORMATION
Ministry of Health

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Unaudited Information

STATEMENT OF REMISSIONS, COMPROMISES AND WRITE-OFFS

FOR THE YEAR ENDED MARCH 31, 2017

(UNAUDITED)

(in thousands)

	2017	2016
Write-Offs		
Medical Claim Recoveries	$ 2,953	$ 2,135
Pharmaceuticals and Health Benefits	-	2,106
Other Receivables	539	428
Total remissions, compromises and write-offs [1]	$ 3,492	$ 4,669

[1] There were no remissions or compromises made.

The above statement has been prepared pursuant to Section 23 of the *Financial Administration Act*. The statement includes all remissions, compromises and write-offs made or approved during the fiscal year.

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Other Statutory Reports

Public Interest Disclosure Act

Section 32 of the *Public Interest Disclosure Act* requires the Ministry to report annually on the following parts of the Act:

(a) the number of disclosures received by the designated officer, the number of disclosures acted on and the number of disclosures not acted on by the designated officer

(b) the number of investigations commenced by the designated officer as a result of disclosures;

(c) in the case of an investigation that results in a finding of wrongdoing, a description of the wrongdoing and any recommendations made or corrective measures taken in relation to the wrongdoing or the reasons why no corrective measure was taken.

There were no disclosures of wrongdoing filed with the Public Interest Disclosure Office, pursuant to the Act, for the ministry between April 1, 2016, and March 31, 2017.

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